Health Insurance

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Introduction

What Are My Health Plan Choices?

Your health plan choices include the State Health Plan (the Standard Plan, the Savings Plan and, if you are enrolled in Medicare, the Medicare Supplemental Plan); traditional Health Maintenance Organizations (BlueChoice® HealthPlan of South Carolina, Inc., and CIGNA HealthCare) and a Point of Service plan (MUSC Options).

All health plans offered through the Employee Insurance Program (EIP) are self-insured. EIP does not pay premiums to an insurance company. Subscribers' monthly premiums and their employer's contribution are placed in a trust account maintained by the state. This account is used to pay claims and administrative costs.

To learn about eligibility, enrollment and other features that are common to all health plans offered through EIP, see the General Information chapter, which begins on page 7.

A Valuable Preventive Benefit:

If you are an active or a retired employee and the Standard Plan, the Savings Plan or one of the HMOs is your primary coverage, you and your covered spouse may participate yearly in a worksite screening sponsored by Prevention Partners. For a $15 copayment, you will receive a comprehensive health appraisal that includes a blood test and an evaluation of your risk factors. Check with your benefits administrator to find out when a screening is scheduled in your area.

The State Health Plan

The State Health Plan offers active employees the **Standard Plan** and the **Savings Plan**. Regardless of which plan you choose, it is important that you understand how your plan works.

The **Standard Plan** has higher premiums but lower deductibles than the Savings Plan. When one family member meets his deductible, the Standard Plan will begin to pay benefits for him, even if the family deductible has not been met. Under the Standard Plan, when you buy a prescription drug you make a copayment, rather than pay the allowable charge. (The *allowable charge* is the maximum amount a health plan will pay for a covered service or product, such as a drug. Network providers have agreed to accept the allowable charge.) You do not have to meet your deductible to receive the prescription drug benefit.

As a **Savings Plan** subscriber you take greater responsibility for your healthcare costs and accept a higher annual deductible. As a result, you save money on premiums. Because it is a tax-qualified, high deductible health plan, eligible subscribers who enroll in the Savings Plan and who have *no other health coverage, including Medicare,* unless it is another high deductible health plan, may establish a Health Savings Account. Funds in this account may be used to pay qualified medical expenses now and in the future.

The *Plan of Benefits* contains a complete description of the plan. Its terms and conditions govern all health benefits offered by the state. To review this document, contact your benefits administrator or EIP.

How SHP Benefits are Paid

The Employee Insurance Program contracts with companies, such as BlueCross BlueShield of South Carolina, to process medical claims; APS Healthcare, Inc., to process mental health and substance abuse claims; and Medco Health Solutions, Inc., to process prescription drug claims. About four percent of EIP's budget goes to pay these claims processors.

Subscribers share the cost of their covered benefits by paying deductibles, coinsurance and copayments for covered services.

BENEFITS AT A GLANCE

<u>This brief overview of your medical plan is for comparison purposes only.</u> The *Plan of Benefits* governs all health benefits offered by the state.

	Standard Plan	Savings Plan
Annual Deductible	$350 Individual $700 Family	$3,000 Individual $6,000 Family (If more than one family member is covered, no family member will receive benefits, other than preventive, until the $6,000 annual family deductible is met.)
Per-occurrence Deductibles:		
Emergency Care[1]	$125	None
Outpatient Hospital[2]	$75	None
Physician Office Visit[3]	$10	None
Coinsurance: Network	20% You Pay 80% State Pays	20% You Pay 80% State Pays
Out-of-network[4]	40% You Pay 60% State Pays	40% You Pay 60% State Pays
Coinsurance maximum: Network	$2,000 Individual $4,000 Family	$2,000 Individual $4,000 Family
Out-of-network[4]	$4,000 Individual $8,000 Family	$4,000 Individual $8,000 Family
Lifetime Maximum	$1,000,000	$1,000,000
Prescription Drug Deductible per Year[4]	No Annual Deductible	**Prescription Drugs** You pay the full allowable charge for prescription drugs, and the cost is applied to your annual deductible.
Retail Copayments for up to a 31-day supply (Participating pharmacies only)[4]	$10 Tier 1 (Generic – lowest cost) $25 Tier 2 (Brand – higher cost) $40 Tier 3 (Brand – highest cost)	After you reach your deductible, you continue to pay the full allowable charge for prescription drugs. However, the plan will reimburse you for 80% of the allowable charge of your prescription. You pay the remaining 20% as coinsurance.
Mail Order and Retail Maintenance Network Copayments for up to a 90-day supply[4]	$25 Tier 1 (Generic – lowest cost) $62 Tier 2 (Brand – higher cost) $100 Tier 3 (Brand – highest cost)	
Prescription Drug Copayment Maximum[4]	$2,500 per person (applies to prescription drugs only)	You must use participating pharmacies. Drug costs are applied to your plan's in-network coinsurance maximum: $2,000 - individual; $4,000 - family. After the coinsurance maximum is met, the plan pays 100% of allowable charges.
Tax-favored Medical Accounts	Medical Spending Account	Health Savings Account Limited-use Medical Spending Account

[1]Waived if admitted.
[2]Waived for dialysis, routine mammograms, routine pap tests, clinic visits, ER, oncology, electro-convulsive therapy, psychiatric medication management and therapy visits.
[3]Waived for routine Pap smear, routine mammograms and well child care.
[4]There are no out-of-network benefits for mental health and substance abuse services or prescription drugs.

HOW THE STANDARD PLAN WORKS

Annual Deductible

The annual deductible is the amount of covered medical expenses (including mental health and substance abuse expenses) you must pay each year before the plan begins to pay benefits.
The annual deductibles are:

- $350 for individual coverage
- $700 for family coverage.

If you have Standard Plan individual coverage, once you meet the $350 deductible, the Standard Plan will begin to pay a percentage of your covered medical expenses.

Under the Standard Plan, the family deductible is the same, regardless of how many family members are covered. The $700 family deductible may be met by any combination of two or more family members' individual covered medical expenses, as long as they total $700. For example, if five people each have $140 in covered expenses, the family deductible has been met, even if no one person has met the $350 individual deductible. Once any one person has paid the $350 individual deductible, he will begin receiving benefits. No one family member may pay more than $350 toward the family deductible.

If the employee and his spouse, who is also covered as an employee or retiree, wish to share the same family deductible, both spouses must select the same health plan.

If you are covered under the Standard Plan, you pay copayments for drugs, up to a maximum of $2,500 per covered family member. Your drug costs do not apply to your deductible.

Per-occurrence Deductible

A per-occurrence deductible is the amount you must pay before the Standard Plan begins to pay benefits each time you receive services in a professional provider's office, visit an emergency room or receive outpatient hospital services. It does not apply to your annual deductible or to your coinsurance maximum.

The deductible for each visit to a professional provider's office is $10. This deductible is waived for routine Pap tests, routine mammograms and well child care visits. Here is an example of how it works:

- If the SHP Standard Plan allowed $56 for a physician's visit, you would first pay the $10 per-occurrence deductible. Then, if you have not met your annual deductible, the remaining $46 would apply toward your annual deductible. (You owe $56.)

- If you have met your annual deductible, the Standard Plan would pay 80 percent of the $46, or $36.80, and you would be responsible for the remaining $9.20, as well as for your $10 per occurrence deductible. (You owe $19.20.)

The deductible for each emergency room visit is $125. This deductible is waived if you are admitted to the hospital. The deductible for each outpatient hospital service is $75. This deductible is waived for dialysis, routine mammograms, routine Pap tests, clinic visits (an office visit at an outpatient facility), and emergency room, oncology, electro-convulsive therapy, psychiatric medication management and therapy visits.

Coinsurance

After your annual deductible has been met, the Standard Plan pays 80 percent of your covered medical, mental health and substance abuse allowable expenses if you use network providers. You pay the remaining 20 percent as coinsurance. If you use non-network providers, the plan pays 60 percent of your covered expenses. You pay the remaining 40 percent of the billed charges as coinsurance. This is applied to your

coinsurance maximum. Even after you meet your annual deductible under the Standard Plan, you must continue to pay per-occurrence deductibles, and they do not apply to your coinsurance maximum.

If you use a provider outside the SHP network, you must pay any amount above the plan's allowable charge for a covered medical expense. You also will have to pay an additional 20 percent in coinsurance. **Prescription drugs and mental health and substance abuse benefits will be paid only if you use a network provider.**

A different coinsurance rate applies for infertility treatments and prescription drugs associated with infertility. See page 47.

What does it mean when a provider does not participate in the network?

For information on providers who do not participate in the network and the "out-of-network differential," see page 38.

Coinsurance Maximum (Out-of-pocket Limit)

The maximum amount in coinsurance you must pay for covered services each year under the Standard Plan is $2,000 for individual coverage or $4,000 for family coverage for network services and $4,000 for individual coverage and $8,000 for family coverage for non-network services. The State Health Plan will then pay 100 percent of the allowable charges. Your payments for non-covered services, prescription drugs, per-occurrence and annual deductibles and penalties for not calling Medi-Call or APS Healthcare do not count toward your coinsurance maximum.

Before the plan will begin paying 100 percent of a covered person's covered prescription drug expenses, the person must pay $2,500 in prescription drug copayments.

HOW THE SAVINGS PLAN WORKS

Annual Deductible

The annual deductible is the amount of covered medical expenses (including medical, prescription drugs and mental health and substance abuse) you must pay each year before the Savings Plan begins to pay a percentage of your covered medical expenses. The annual deductibles are:

- $3,000 for individual coverage
- $6,000 for family coverage.

There is no individual deductible if more than one family member is covered. The family deductible is not considered met for any covered individual until total covered expenses exceed $6,000. For example, even if one family member has $3,001 in covered medical expenses, he will not begin receiving benefits until his family has $6,000 in covered expenses. However, if the subscriber has $1,000 in expenses, the spouse has $3,001 in expenses and another child has $2,000 in expenses, all family members will begin to receive benefits.

If you are covered under the Savings Plan, you pay the full allowable charge for covered prescription drugs, and the amount is applied to your deductible. After your deductible has been met, you receive reimbursement for 80 percent of your allowable charges. After your coinsurance maximum has been met, you receive reimbursement for 100 percent of your allowable charges.

There are **no** per-occurrence deductibles under the Savings Plan. You pay the full allowable charge for services, and it is applied to your annual deductible.

Coinsurance

After your annual deductible has been met, the Savings Plan pays 80 percent of your covered medical, prescription drug, mental health and substance abuse expenses if you use network providers. You pay the

remaining 20 percent as coinsurance. The amount you pay to network providers contributes to your coinsurance maximum. If you use non-network providers, the plan pays 60 percent of your covered expenses. You pay the remaining 40 percent as coinsurance.

If you use a non-network provider, any charge above the plan's allowable charge for a covered medical expense is your responsibility. You will also have to pay the additional 20 percent in coinsurance, a total of 40 percent. See page 38 to learn more about this "out-of-network differential." Prescription drug and mental health and substance abuse benefits will be paid **only** if you use a network provider.

A different coinsurance rate applies for infertility treatments and prescription drugs associated with infertility, see page 47.

Coinsurance Maximum (Out-of-pocket Limitation)

The maximum amount in coinsurance you must pay for covered services each year under the Savings Plan is $2,000 for individual coverage or $4,000 for family coverage for network services and $4,000 for individual coverage or $8,000 for family coverage for non-network services. The Savings Plan will then pay 100 percent of the allowable charges. Your payments for non-covered services, annual deductibles and penalties for not calling Medi-Call or APS Healthcare do not count toward your coinsurance maximum.

LIFETIME MAXIMUM

The maximum amount the State Health Plan will pay for each person for all benefits is $1,000,000. This lifetime maximum includes all payments made for a person while covered under any State Health Plan option, including the Savings, Standard and Medicare Supplemental plans and the Economy Plan, which is no longer offered. It applies regardless of any break in coverage or whether the person is enrolled in one of the plans as a dependent, an employee or a retiree.

COORDINATION OF BENEFITS

All State Health Plan (SHP) benefits, including prescription drug and mental health benefits, are subject to coordination of benefits (COB). COB is a system to make sure a person covered under more than one insurance plan is not reimbursed more than once for the same expenses.

For more information about COB, including how third-party administrators determine which plan pays first, see page 19.

Here are some specific features of coordination of benefits under the Standard Plan and the Savings Plan:

On your Notice of Election form, you are asked if you are covered by more than one group insurance plan. Your response is recorded and is placed in your file. However, the third-party administrator, BlueCross BlueShield of South Carolina (BCBSSC), may ask you this question every year, by sending you a questionnaire. **Please complete this form and return it to BlueCross BlueShield of South Carolina in a timely manner, since claims will not be processed or paid until your information is received.** You can also update this information by calling BCBSSC or by visiting www.SouthCarolinaBlues.com.

This is how the SHP works when it is secondary insurance:

- The SHP will pay the lesser of: 1) what it would pay if it were the primary payer; or 2) the part of the covered charge not paid by the primary payer.
- The SHP's limit on balance billing does not apply. This means if the provider charges more than the plan's allowable charge, you will be responsible for the extra cost.
- You will also be responsible for your deductible, if it has not been satisfied, and for your coinsurance.

- For a medical claim, you or your provider must file the Explanation of Benefits from your primary plan directly with BlueCross BlueShield of South Carolina.
- For mental health and substance abuse benefits, you must file the Explanation of Benefits from your primary plan directly with APS Healthcare, Inc.
- For prescription drug benefits, you must present your card for your primary coverage first. Otherwise, the claim will be rejected because the pharmacist's electronic system will indicate that the SHP is secondary coverage. After the pharmacy processes the claim with your primary coverage, you must file a paper claim through Medco for any secondary benefits to be paid. Prescription drug claim forms are available on the EIP Web site at www.eip.sc.gov. Choose your category, and then click on "Forms." You may also ask your benefits administrator for a copy of the form.

Please remember: The SHP is not responsible for filing or processing claims for a subscriber through another health insurance plan. That is your responsibility.

SUBROGATION

To the extent provided by South Carolina law, the State Health Plan has the right to recover payment in full for benefits provided to a covered person under the terms of the Plan when the injury or illness occurs through the act or omission of another person, firm, corporation or organization. If a covered person receives payment for such medical expenses from another who caused the injury or illness, the covered person agrees to reimburse the Plan in full for any medical expenses paid by the Plan.

USING SHP PROVIDER NETWORKS

The choice is yours. When you are ill or injured, you decide where to go for your care. The SHP is a *preferred provider organization (PPO)*. It has network arrangements with physicians, hospitals, ambulatory surgical centers and mammography testing centers. There are also networks available to State Health Plan subscribers for independent durable medical equipment, lab, radiology and X-ray, physical therapy, occupational therapy, speech therapy, skilled nursing facilities, long term acute care facilities, hospice providers and dialysis centers. They have agreed, as part of our networks, to accept the plan's allowable charges for covered medical services as payment in full and will not balance bill you. **Network providers will charge you for your deductibles and coinsurance when the services are provided. They will also file your claims.**

If you use an out-of-network medical provider or your physician sends your laboratory tests to an out-of-network provider, your costs will increase. This applies to your medical benefits. Prescription drug and mental health and substance abuse benefits are only paid if you use a network provider.

How to Find a Medical Network Provider

Paper copies of the State Health Plan provider directory are no longer distributed. There are two ways to view the online directory. On EIP's Web site, www.eip.sc.gov, choose your category and then select "Online Directories." Click on "State Health Plan Doctor/Hospital Finder." You may also go directly to the BlueCross BlueShield of South Carolina Web site, www.southcarolinablues.com. At the site:

- Under "Find a Doctor Or Other Healthcare Provider," choose "South Carolina."
- Choose "Blue Cross and Blue Shield" as the directory. Check to show whether you want to look for a provider by "Location" or by "Name." Then select a "Healthcare Professional Type" from the drop-down menu.
- A menu will enable you to select a city or county, a health plan (State Health Plan) and a specialty.

If you do not have access to the Internet, call BlueCross BlueShield of South Carolina at 803-736-1576 (Greater Columbia area) or 800-868-2520 (toll-free outside the Columbia area) to request that a list of State Health Plan providers in your area be mailed to you.

Network providers include physicians or extended role nurses in these specialties:

- Allergy
- Anesthesiology
- Cardiology (heart and blood vessels)
- Chiropractic
- CNM (Certified Nurse Midwife)
- CRNA (nurse anesthetist)
- Dermatology (skin)
- Endocrinology (hormones, glands)
- Family Practice
- General Practice
- General Surgery
- Geriatrics (the elderly)
- Gynecology (women's reproductive health)
- Internal Medicine (non-surgical diseases in adults)
- Laboratory
- Nephrology (kidney disease)
- Neurological Surgery (nervous system and brain surgery)
- Neurology (nervous system)
- Nurse Practitioner
- OB/GYN (women's reproductive health and child bearing)
- Obstetric (child bearing)
- Oncology (cancer)
- Ophthalmology (eye diseases)
- Optometry (measuring and treating vision problems)
- Oral Surgery (mouth surgery)
- Orthopedic Surgery (bone surgery)
- Otolaryngology (ear, nose and throat)
- Pathology (examination of body tissue and fluids)
- Pediatrics (treatment of children)
- Plastic Surgery (reconstruction of tissue and bone)
- Podiatry (feet)
- Proctology (rectum)
- Pulmonary Disease (lungs)
- Radiology (X-ray)
- Rheumatology (joints and muscles)
- Thoracic Surgery (chest)
- Urology (bladder, kidney and urinary tract)

BLUECARD WORLDWIDE®

When you need medical care **outside South Carolina**, you have access to doctors and hospitals throughout the United States and around the world through the BlueCard Program and Blue Cross Blue Shield provider networks. If you need mental health or substance abuse care outside South Carolina, please call APS Healthcare at 800-221-8699.

Inside the U.S.

With the BlueCard program you can choose the doctors and hospitals that best suit you and your family. Follow these steps for health coverage when you are away from home but within the United States:

1. Always carry your State Health Plan ID card.
2. In an emergency, go directly to the nearest hospital.
3. To find the names and addresses of nearby doctors and hospitals, visit the BlueCard Doctor and Hospital Finder Web site (www.BCBS.com) or call BlueCard *Access* at 800-810-2583.
4. Call Medi-Call for preauthorization within 48 hours of receiving emergency care. The toll-free number is on your State Health Plan ID card.
5. When you arrive at the participating doctor's office or hospital, show your identification card. As a BlueCard program member, the doctor will recognize the logo, which will ensure that you will get the highest level of benefits with no balance billing.
6. The provider should file claims with the Blue Cross Blue Shield affiliate in the state where the services were provided.

After you receive care, you should not have to complete any claim forms, nor should you have to pay up front for medical services other than the usual out-of-pocket expenses (deductibles, copayments, coinsurance and non-covered services). You will be mailed an explanation of benefits by BlueCross BlueShield of South Carolina.

Outside the U.S.

Through the BlueCard Worldwide® program, your State Health Plan ID card gives you access to doctors and hospitals in more than 200 countries and territories around the world and to a broad range of medical assistance services.

To take advantage of the BlueCard Worldwide® program, please follow these steps:

1. Always carry your current State Health Plan ID card.
2. In an emergency, go directly to the nearest hospital.
3. Before your trip:
   - If you have questions, call the phone number on the back of your ID card to check your State Health Plan benefits and for preauthorization, if necessary. (Your healthcare benefits may be different outside the U.S.)
   - Call the BlueCard Worldwide® Service Center toll-free at 800-810-2583 or collect at 804-673-1177 to find providers in the area where you will be traveling.
4. During your trip:
   - If you need to locate a doctor or hospital or need medical assistance, call the BlueCard Worldwide® Service Center toll-free at 800-810-2583 or collect at 804-673-1177 (24 hours a day, seven days a week).
   - If you are admitted to the hospital, call the BlueCard Worldwide® Service Center toll-free at 800-810-2583 or collect at 804-673-1177.
   - The BlueCard Worldwide® Service Center will work with the State Health Plan to arrange direct billing with the hospital for your inpatient stay.
   - When direct billing is arranged, you are responsible for the out-of-pocket expenses (non-covered services, deductibles, copayment, and coinsurance) you normally pay. The hospital will submit your claim on your behalf.
   - **Note:** If direct billing is not arranged between the hospital and your plan, you will need to pay the bill up front and file a claim.
5. For outpatient care and doctor visits, you will need to pay the provider at the time you receive care and file a claim.
6. To file a claim for services you paid for when you received care or paid to providers that are not part of the BlueCard Worldwide® network, complete a BlueCard Worldwide® international claim form and send it with the itemized bill(s) to the BlueCard Worldwide® Service Center. The claim form is available online at www.BCBS.com, or by calling the BlueCard Worldwide® Service Center toll-free at 800-810-2583 or collect at 804-673-1177 or through EIP's Web site. The address of the service center is on the claim form. BlueCard Worldwide® will arrange billing to BlueCross BlueShield of South Carolina.

Prescription Drug and Mental Health/Substance Abuse Provider Networks

Because the State Health Plan offers no out-of-network coverage for prescription drugs or mental health/substance abuse care, it is important that you find a participating network provider for these services. The most up-to-date lists of network providers are on Web sites sponsored by Medco Health Solutions, Inc., the prescription drug benefit manager, and APS Healthcare, Inc., the mental health and substance abuse manager. These sites are accessible through the EIP Web site, www.eip.sc.gov. Choose your category and then select "Online Directories." You will see a list of links to provider directories. You can also go there directly:

- To see the list of network pharmacies, go to www.medco.com.
- Mental health and substance abuse providers include: psychiatrists, clinical psychologists, masters-level therapists and nurse practitioners. To see the list, go to the APS Healthcare, Inc., Web site at www.apshealthcare.com. Click on "Information for Members." Then select "State of South Carolina" from the drop-down list under "Employers." Then click on "Online Provider Locator." The access code is "statesc." Finally, click on "Submit." You also may call APS Healthcare toll-free at 800-221-8699 to be directed to a network provider and to receive the required preauthorization.

For more information on your prescription drug benefits, see page 54. For more information on your mental health and substance abuse benefits, see page 58.

If you do not have access to the Internet, paper copies of the provider directories are available from your benefits office or, if you are a retiree, survivor or COBRA participant, from APS.

OUT-OF-NETWORK BENEFITS FOR MEDICAL CARE

Remember, there is no out-of-network coverage for **prescription drugs**. For **mental health and substance abuse care**, there is no coverage if you use an out-of-network provider or if you fail to have services preauthorized.

You can use providers who are not part of the network and still receive some coverage for medical care. However, before the State Health Plan will pay 100 percent of allowed charges:

- **Standard Plan and Savings Plan** subscribers have a $4,000 individual coinsurance maximum for out-of-network services and an $8,000 family coinsurance maximum for out-of-network services.

Subscribers to both plans may also have to fill out claim forms.

Balance Billing

If you use a provider who is not part of the network, you may be subject to "balance billing." When the State Health Plan is your primary coverage, network providers are prohibited from billing you for covered services except for copayments, coinsurance, and deductibles. However, a non-network provider may choose to bill you for more than the plan's allowable charge for the covered service. The difference between what the non-network provider charges and the allowable charge is called the "balance bill." The balance bill does not contribute toward meeting your annual deductible or coinsurance maximum.

OUT-OF-NETWORK DIFFERENTIAL

In addition to balance billing, if you choose a provider that does not participate in the State Health Plan or BlueCard network, you will pay 40 percent, instead of the usual 20 percent, in coinsurance.

These examples show how it would have cost you more money to use a non-network provider:

You have employee-only coverage under the SHP and you have not met your deductible. The non-network provider charges $5,000 for the covered services you receive, but the SHP maximum allowance is $4,000.

Standard Plan

Your out-of-pocket costs for services from a **network provider** would have been $1,080.

However, if you had used a non-network provider for the same services:

You pay the $350 Standard Plan deductible. Then $3,650 remains of the Standard Plan responsibility. The plan pays 60 percent of that, $2,190. The remaining $1,460 coinsurance and the $1,000 "balance billing" from the non-network provider are your responsibility. Therefore, $1,460 is applied toward your $4,000 out-of-network coinsurance maximum.

$4,000	SHP allowance	$3,650	Standard Plan responsibility
- 350	Standard Plan deductible for 2008	-2,190	Standard Plan pays
$3,650	Standard Plan responsibility	1,460	You pay as coinsurance
x 60%	Standard Plan coinsurance	1,000	Your balance bill from provider
$2,190	Standard Plan pays	+ 350	Your Standard Plan deductible
		$2,810	**Your out-of-pocket costs for the services of a non-network provider**

Standard Plan subscribers also pay any per-occurrence deductibles (which do not apply toward your annual deductible) both in-network and out-of-network. They are not included in this example.

Savings Plan

Your out-of-pocket costs for the services of a **network provider** would have been $3,200.

However, if you had used a non-network provider for the same services:

You pay the $3,000 Savings Plan deductible. Then $1,000 remains of the Savings Plan responsibility. The plan pays 60 percent of that, or $600. The remaining $400 coinsurance, as well as the $1,000 "balance billing" from the non-network provider, is your responsibility. The $400 in coinsurance is applied to your $4,000 out-of-network coinsurance maximum.

$4,000	SHP allowance	$1,000	Savings Plan responsibility
- 3,000	Savings Plan deductible for 2008	- 600	Savings Plan pays
$1,000	Savings Plan responsibility	400	You pay as coinsurance
x 60%	Savings Plan coinsurance	1,000	Your balance bill from provider
$ 600	Savings Plan pays	+3,000	Your Savings Plan deductible
		$4,400	**Your out-of-pocket costs for the services of a non-network provider**

MANAGING YOUR MEDICAL CARE

MEDI-CALL

Some services provided under the State Health Plan require preauthorization before you receive them as a covered benefit. A phone call gets things started. While your healthcare provider may make the call for you, it is your responsibility to see that the call is made.

You can reach Medi-Call by phone from 8:30 a.m. to 5 p.m., Monday through Friday, except holidays. You may fax information to Medi-Call 24 hours a day. However, Medi-Call will not respond until the next business day. If you do fax information to Medi-Call, provide, at a minimum, this information so the review can begin:

- Subscriber's name
- Patient's name
- Subscriber's Benefits ID Number or Social Security Number
- Information about the service requested
- A telephone number where you can be reached during business hours.

Medi-Call numbers are:

- 800-925-9724 (South Carolina, nationwide, Canada)
- 803-699-3337 (Greater Columbia area)
- 803-264-0183 (fax)

Medi-Call promotes high-quality, economical care for you and your covered family members through reviews that assess, plan, implement, coordinate, monitor and evaluate health care options and services required to meet an individual's needs. You must contact Medi-Call at least 48 hours or two working days, whichever is greater, before receiving any of these medical services at any hospital in the U.S. or Canada:

- You need inpatient care in a hospital[1]
- Your preauthorized outpatient services result in a hospital admission. (You must call again for the hospital admission.)
- You need outpatient surgery for a septoplasty
- You need outpatient or inpatient surgery for a hysterectomy
- You need sclerotherapy performed in an inpatient, outpatient or office setting

- You need a MRA, MRI, PET or CT Scan
- You will be receiving a new course of chemotherapy or radiation therapy (one-time notification per course)
- You are admitted to a hospital in an emergency (Your admission must be reported within 48 hours or the next working day after a weekend or holiday admission.)[1]
- You are pregnant (You must call within the first three months of your pregnancy.)
- You have an emergency admission during pregnancy[2]
- Your baby is born[2]
- Your baby has complications at birth
- You are to be, or have been, admitted to a long-term acute care facility, skilled nursing facility, need home healthcare, hospice care or an alternative treatment plan
- You need durable medical equipment
- You or your covered spouse decides to undergo in vitro fertilization, GIFT, ZIFT or any other infertility procedure
- You or your covered family member needs to be evaluated for a transplant
- You need inpatient rehabilitative services and related outpatient physical, speech or occupational therapy.

Whether you are enrolled in the Standard Plan or in the Savings Plan, you are required to participate in Medi-Call.

A preauthorization request for any procedure that may potentially be considered cosmetic in nature must be received in writing by Medi-Call seven days before surgery. (Procedures in this category include: blepharoplasty, reduction mammoplasty, augmentation mammoplasty, mastopexy, TMJ or other jaw surgery, panniculectomy, abdominoplasty, rhinoplasty or other nose surgery, etc.) Your physician should include photographs if appropriate.

[1]For mental health or substance abuse services, you must call APS Healthcare at 800-221-8699 for preauthorization before a non-emergency admission or within 24 hours of an emergency admission.
[2]Contacting Medi-Call for the delivery of your baby does not add the baby to your health insurance. You must add your child by filing an NOE within 31 days of birth for benefits to be payable.

A determination by Medi-Call that a proposed treatment is within generally recognized medical standards and procedures does not guarantee claim payment. Other conditions, including eligibility requirements, other limitations or exclusions, payment of deductibles and other provisions of the plan must be satisfied before BlueCross BlueShield of South Carolina makes payment. Remember, if you choose a non-network provider, your financial responsibility will be greater.

Are There Penalties for Not Calling?

Yes. If you do not call Medi-Call in the required situations, you will pay a $200 penalty for **each** hospital or skilled nursing facility **admission.** In addition, the coinsurance maximum will not apply. In other words, you will continue to pay your coinsurance, no matter how much you pay out-of-pocket. If you do not obtain preauthorization from APS HealthCare, no mental health or substance abuse benefits will be paid.

MATERNITY MANAGEMENT

Regular prenatal care and following your doctor's recommendations can help protect your health and your baby's health. If you are a mother-to-be, **you must participate in the Maternity Management Program**. Medi-Call administers EIP's comprehensive maternity management program, "Coming Attractions." The program monitors expectant mothers throughout pregnancy and manages Neonatal Intensive Care Unit (NICU) infants or other babies with special needs until they are 1 year old. **You must call Medi-Call during the first trimester (three months) of your pregnancy to preauthorize your pregnancy benefits**. If you do not call Medi-Call during the first trimester, or if you refuse to participate in the Maternity Management Program, you will pay a $200 penalty for **each** maternity-related hospital or skilled nursing

facility **admission**. This penalty will be in addition to the Medi-Call preauthorization penalty, and the $2,000 coinsurance maximum will not apply.

Participating in the Maternity Management Program or contacting Medi-Call about the birth of your baby does not add your baby to your health insurance. Even if you have Full Family or Employee/Children coverage, you must add him to your policy by completing an NOE within 31 days of his birth.

You are automatically enrolled in "Coming Attractions" when you call Medi-Call to preauthorize your pregnancy. As a participant in the program, you will receive a phone call from a Medi-Call nurse, a welcome letter from Medi-Call and a packet of information to refer to during your pregnancy.

A Medi-Call maternity nurse will complete a Maternity Health Assessment form when you enroll. This assessment is used to identify potential high-risk factors during your first trimester. If high-risk factors are identified, you will be scheduled for follow-up calls. If no risks are identified, you should call with any changes in your condition. Otherwise, your Medi-Call nurse will send you a reminder card with benefit information during your third trimester, and she will call you after your baby is born.

Also, you can call Medi-Call anytime you have questions. A maternity case management nurse will be there to help you throughout your pregnancy.

MANAGING FOR TOMORROW®

If you have a chronic condition, such as diabetes, asthma, coronary artery disease, chronic obstructive pulmonary disease, congestive heart failure, hyperlipidemia or hypertension, taking care of yourself is a 24-hour-a-day, seven-day-a-week job. Managing your healthcare starts with understanding your condition and your doctor's plan for your treatment.

Managing for Tomorrow® can help. It is available to active employees, retirees who are not eligible for Medicare, spouses and dependents covered by the Standard Plan and the Savings Plan. You may receive a letter or phone call about this disease-management program, which is sponsored by BlueCross BlueShield of South Carolina in cooperation with Prevention Partners.

The program is designed to help you learn more about your condition and how to improve your health. Often the daily choices made by a person with a chronic disease can improve his health or make it worse. The program is voluntary and free. You will not be asked to purchase anything, your benefits will not be affected, and your premiums or copayments will not increase whether or not you participate in Managing for Tomorrow.®

The program starts with an invitation to participate in a confidential survey. The survey helps determine which programs and services are right for you. You will receive a special Personal Identification Number (PIN). This PIN will allow you to complete the survey by calling an automated phone line or by logging on to a secure Web site. Paper surveys also are available. The survey is designed to determine how the program can help you. You will receive a personalized response to your survey, health guides, home management or testing kits, seasonal newsletters and individual counseling calls.

A disease management program can assist you in managing your symptoms by helping you understand your conditions and treatment plan. Disease management nurses may talk with you on the phone or in person to provide the information and support you need to help control symptoms and complications of chronic conditions. They can also help you make lifestyle changes that enable you to be as healthy as possible.

Everyone who receives an invitation is encouraged to take part in the program. If you think you qualify, but have not been invited to participate, call Medi-Call at 803-699-3337 (Greater Columbia area) or 800-925-9724 (South Carolina, the U.S. and Canada). Follow the prompts. As a "Member," press 2. Then press 2, the number for "all other inquiries." When you reach an operator, ask to speak with a coordinator in the "Managing for Tomorrow" program.

WELLNESS MANAGEMENT

Personal Health Assessment (PHA)

An online Personal Health Assessment (PHA) is available to State Health Plan subscribers who are 18 years and older through the BlueCross BlueShield of South Carolina Web site, www.SouthCarolinaBlues.com. Log on the "Member My Insurance Manager" and then click on the "My HealthCenter" link, which is under the "Access Online Programs and Added Values" heading. Select your name from the drop-down menu on the next page and then click on "Continue." Then click on "Personal Health Assessment" to take the survey.

The survey asks questions in nine categories and then provides a wellness score based on the responses. It enables you to evaluate your health and gives suggestions for lifestyle changes.

You can print your PHA results and recommendations, and you will continue to have access to them online. The program is on a secure Web link, and all assessments remain confidential. You can retake the survey each year to measure your progress toward your health goals.

Weight Management Program

The BlueCross Weight Management program is designed to help you achieve weight loss goals through small changes you can sustain while still getting on with your life. Food Awareness Training and realistic goal setting are two key parts of this program. Program candidates are identified through claims analysis, authorizations, doctor referral or self-referral.

If you think you qualify, but have not received an invitation to participate, call Medi-Call at 803-699-3337 (Greater Columbia area) or 800-925-9724 (South Carolina, the U.S. and Canada.) Follow the prompts. As a "Member," press 2. Then press 2, the number for "all other inquiries." When you reach an operator, ask to speak with a coordinator in the Weight Management Program.

Medical Cost Estimator

The cost estimator is available on the BlueCross BlueShield of South Carolina Web site, www.SouthCarolinaBlues.com. It can help you determine how much a medical service or procedure will cost. This can be useful in budgeting for medical expenses and planning for the cost of certain health conditions. The estimator provides a cost range for an illness, breaks cost down by type of care (e.g., medical, durable medical equipment, drugs, etc.) and compares costs by setting (e.g., inpatient versus outpatient). The cost estimator can help you plan contributions to a Flexible Spending Account or a Health Savings Account.

Provider Report Card

BlueCross BlueShield of South Carolina gives you access to a Provider Report Card through its Web site, www.SouthCarolinaBlues.com. This tool allows you to compare hospitals in the same part of the state to determine the number of patients treated, complication rate and how long patients usually stay in the hospital. You can then use this information to help decide which hospital to use.

MEDICAL CASE MANAGEMENT

Facing a serious illness or injury can be confusing and frustrating. You may not know where to find support or information to help you cope with your illness, and you may not know what treatment options are available. Case management may help.

Three case management programs are available to those enrolled in the State Health Plan. Each program includes teams of specially trained nurses and doctors. The goal of the programs is to assist participants in coordinating, assessing and planning healthcare. It does so by giving each patient control over his healthcare and respecting his right to knowledge, choice, a direct relationship with his physician, privacy and dignity.

None of the programs provide medical treatment, and all recognize that ultimately decisions about your care are between you and the treating physician. Each program may involve a home or facility visit to a participant but only with permission.

By working closely with your doctor, using your benefits effectively and using the resources in your community, the case management programs may help you through a difficult time. If you would like more information on any of these programs, call 800-925-9724 and ask to be transferred to the case management supervisor.

BlueCross Medi-Call Case Management Program

This case management program is designed for people enrolled in the State Health Plan who have specific catastrophic or chronic disorders, acute illnesses or serious injuries. The case management program facilitates continuity of care and support of these patients while managing health plan benefits in a way that promotes high-quality, cost-effective outcomes.

Case managers talk with patients, family members and providers to coordinate services among providers and support the patient through a crisis or chronic disease. Case management intervention may be short- or long-term. Case managers combine standard preauthorization services with innovative approaches for patients who require high levels of medical care and benefits. Case managers can often arrange services or identify community resources available to meet the patient's needs.

The case manager works with the patient and the providers to assess, plan, implement, coordinate, monitor and evaluate ways of meeting a patient's needs, reducing readmissions and enhancing quality of life. Your Medi-Call nurse case manager may visit you in your home, with your permission, or in a treatment facility or your physician's office when the treatment team determines it is appropriate.

A Medi-Call nurse stays in touch with the patient, caregivers and providers to assess and re-evaluate the treatment plan and the patient's progress. All communication between BlueCross BlueShield of South Carolina and the patient, family members or providers complies with HIPAA privacy requirements. If a patient refuses medical case management, Medi-Call will continue to preauthorize appropriate treatment.

ParadigmHealth® Complex Care Management Program

Some SHP enrollees are referred to ParadigmHealth® for complex care management. The program is designed to assist the most seriously ill patients. They include those with complex medical conditions, who may have more than one illness or injury, who have critical barriers to their care and who are frequently hospitalized.

The complex care management program provides you with information and support through a local care coordinator, who is a registered nurse. This nurse coordinator can help you identify treatment options; locate supplies and equipment recommended by your doctor; coordinate care with your doctor and the SHP; and research the availability of special transportation and lodging for out-of-town treatment. The nurse stays in touch weekly with patients and caregivers to assess and re-evaluate the treatment plan and the patient's progress. This program helps you make informed decisions about your health when you are seriously ill or injured.

Participation in the program is voluntary. You can leave the program at any time, for any reason. Your benefits will not be affected by your participation in the program.

Here is how the program works: BlueCross BlueShield of South Carolina will refer you to ParadigmHealth® if the program may be of benefit to you. You will receive a letter explaining the program, and a ParadigmHealth® representative will contact you. A care coordinator in your area will visit you to discuss ways he can help you and will ask permission to contact your doctor to offer assistance.

The ParadigmHealth® team comprised of specially trained nurses and doctors will review your medical information and treatment plan. (Your medical history and information will always be kept confidential among your caregivers and the ParadigmHealth® team.) Your local care coordinator nurse will be your main program contact. You and your doctor, however, will always make the final decision about your treatment. Complex care management does not replace the care you receive from your doctor. Always check with your doctor before following any medical advice.

A Medi-Call nurse will act as a liaison with the Paradigm nurse. This Medi-Call nurse provides information about the use of benefits and networks and completes authorization for medically necessary services that are covered by the plan.

VillageHealth Disease Management Renal Case Management Program

VillageHealth Disease Management provides renal disease management care for select State Health Plan enrollees with end-stage renal disease (ESRD). These nurses visit patients in dialysis centers and in their homes to provide education and outreach that may help prevent acute illnesses and hospitalizations.

Here is how the program works: SHP subscribers with ESRD are referred to VillageHealth by BlueCross BlueShield of South Carolina. A South Carolina-based VillageHealth nurse then contacts the individual to confirm that he is a good candidate for renal case management. The nurse, who has many years of ESRD experience, coordinates care across all disciplines and facilitates Medi-Call referrals for patients accepted into the program.

As the link between the patient, providers and dialysis team, the nurse identifies the patient's needs through medical record review and consultations with the patient, family and health care team. Needs may be medical, social, behavioral, emotional and financial. The nurse coordinates services based on the long-term needs of the patient and incorporates these needs into a plan agreed upon by the patient, physician(s), dialysis team and other providers. Your VillageHealth nurse may visit you in your home, with your permission, or in the dialysis center when the treatment team determines it is appropriate. He will call you frequently and receive updates from your providers.

A Medi-Call case manager will act as a liaison with the VillageHealth nurse. This Medi-Call nurse provides information about the use of benefits and networks and completes authorization for medically necessary services that are covered by the plan.

STATE HEALTH PLAN BENEFITS

The Standard Plan and the Savings Plan pay benefits for *medically necessary* treatments of illnesses and injuries. This section is only a general description of the plan. The *Plan of Benefits* contains a complete description of the benefits. Its terms and conditions govern all health benefits offered by the state. Contact your benefits administrator or EIP for more information. Some services and treatments require preauthorization by Medi-Call or APS Healthcare. Be sure to read the Medi-Call section beginning on page 39 and the mental health and substance abuse section on page 58 for details.

A *medically necessary* service or supply is:

- Required to identify or treat an illness or injury and
- Prescribed or ordered by a physician and
- Consistent with the covered person's illness, injury or condition and in accordance with proper medical and surgical practices prevailing in the medical specialty or field of medicine at the time rendered and
- Required for reasons other than the convenience of the patient. The fact that a service is prescribed by a physician does not necessarily mean that the service is medically necessary.

Alternative Treatment Plans (ATP)

An alternative treatment plan is an individual program to permit treatment in a more cost-effective and less intensive manner. An ATP requires the approval of the treating physician, Medi-Call and the patient. Services and supplies that are authorized by Medi-Call as medically necessary because of the approved alternative treatment plan will be covered.

Ambulance

Ambulance service, to or from a local hospital outpatient department, is covered when used to provide necessary service in connection with an injury or a medical emergency and to or from the nearest hospital providing necessary service in connection with inpatient care. No benefits are payable for ambulance service used for routine, nonemergency transportation, including, but not limited to, travel to a facility for scheduled medical or surgical treatments, such as dialysis or cancer treatment. All claims for ambulance service are subject to medical review.

Ambulatory Surgical Centers

These facilities provide some of the same services offered in the outpatient department of a hospital. Centers in the network accept the State Health Plan allowable charges. You just pay the applicable deductible and coinsurance. Medically necessary services at non-network ambulatory surgical centers are covered, but you may pay more.

The SHP Standard Plan has per-occurrence deductibles for some services. See page 32 for details.

Chiropractic Care

You are covered for specific office-based services from a chiropractor, including detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and the effects of such nerve interference, where such interference is the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column. Diagnostic X-rays are covered if medically necessary.

Colonoscopies

Subscribers age 50 and older may receive one colonoscopy every ten years even when no symptoms are apparent. The plan also covers diagnostic colonoscopies. All colonoscopies are subject to the plan's deductibles and coinsurance.

Contraceptives

For employees and covered spouses, routine contraceptive prescriptions, including birth control pills and injectables (including, but not limited to, Depo-Provera and Lunelle), filled at a participating pharmacy or through the plan's mail-order pharmacy, are covered as prescription drugs. Birth control implants and injectables, given in a doctor's office, are covered as a medical expense.

Cranial Remodeling Band or Helmet

The plan covers the use of a cranial remodeling band when preauthorization review determines it to be medically necessary for the correction of a child's moderate to severe positional head deformities associated with premature birth, restrictive intrauterine positioning, cervical abnormalities, birth trauma, torticollis or sleeping positions. Remodeling must be initiated between 4 and 12 months of age, following a failed two-month trial of conservative treatment (e.g., repositioning, neck exercises, etc.)

Diabetic Supplies

Insulin is allowed under the prescription drug program or under the medical plan but not under both. Since most insulin is brand name, it requires a $25 copayment for each supply of up to 31 days. Diabetic supplies,

including syringes, lancets and test strips, are covered at participating pharmacies through your drug benefit for a $10 copayment, per item, for each supply of up to 31 days. Claims for diabetic durable medical equipment and insulin should be filed with BlueCross BlueShield of South Carolina.

Doctor Visits

Treatments or consultations for an injury or illness are covered, as long as they are medically necessary and not associated with a service excluded by the plan. For mental health and substance abuse services to be covered, you must use a participating provider, and all mental health and substance abuse services must be preauthorized by APS Healthcare. For details on mental health and substance abuse services, see page 58.

Durable Medical Equipment (DME)

Generally, durable medical equipment must be preauthorized by Medi-Call. Some examples include:

- Any purchase or rental of durable medical equipment
- Any purchase or rental of renal dialysis equipment
- Any purchase or rental of durable medical equipment that has a non-therapeutic use or a potentially non-therapeutic use
- C-Pap or Bi-Pap machines
- Oxygen and equipment for oxygen use outside a hospital setting, whether purchased or rented
- Any prosthetic appliance or orthopedic brace, crutch or lift, attached to the brace, crutch or lift, whether initial or replacement
- Orthopedic shoes.

For more information about Medi-Call, see page 39. You may contact Medi-Call at 803-699-3337 (Greater Columbia area) or 800-925-9724 (South Carolina, nationwide and Canada).

DME provider networks are available to State Health Plan members. These contracting providers can offer you discounts while providing you with high-quality products and care.

Extended-Role Nurse

Expenses for services received from a licensed, independent extended-role nurse are covered, even if these services are not performed under the immediate direction of a doctor. An extended-role nurse is a nurse practitioner, certified nurse midwife, certified registered nurse anesthetist or a clinical nurse specialist. All services received must be within the scope of the nurse's license and needed because of a service allowed by the plan.

The State Health Plan only recognizes certified nurse midwives as providers for purposes of midwife coverage. A certified nurse midwife (CNM) is an advance-practice registered nurse who is licensed by the State Board of Nursing as a midwife. Lay midwives and certified midwives licensed by the S.C. Dept. of Health and Environmental Control (DHEC) are not reimbursed.

Home Healthcare

Home healthcare includes part-time nursing care, health aide service or physical, occupational or speech therapy provided by an approved home healthcare agency and given in the subscriber's home. You cannot receive home healthcare and hospital or skilled nursing facility benefits at the same time. These services do not include custodial care or care given by a person who ordinarily lives in the home or is a member of the subscriber's family or the spouse's family. Benefits are limited to $5,000 or 100 visits per year, whichever is less. These services must be preauthorized by Medi-Call.

Hospice Care

The plan will pay benefits for a terminally ill patient's hospice care. The maximum benefit is $6,000 per covered person, including a maximum of $200 for bereavement counseling. These services must be preauthorized by Medi-Call.

Infertility

The plan will pay benefits for the diagnosis and treatment of infertility for members for whom infertility is not a result of a prior tubal ligation or a vasectomy.

The benefits are limited to a lifetime maximum payment of $15,000 for any covered medical expenses and covered prescription drug expenses incurred by the subscriber or the covered spouse whether covered as a dependent or as an employee. Included in the $15,000 maximum are diagnostic tests, prescription drugs and up to six cycles of Intrauterine Insemination (IUI) and/or a maximum total of three completed cycles of zygote or gamete intrafallopian transfer (ZIFT or GIFT) or in vitro fertilization (IVF) per lifetime. A cycle reflects the cyclic changes of fertility with the cycle beginning with each new insemination or assisted reproductive technology (ART) transfer or implantation attempt. ART procedures not specifically mentioned are not covered, including but not limited to: tubal embryo transfer (TET), pronuclear stage tubal embryo transfer (PROUST) oocyte donation and intracytoplasmic sperm injection (ICSI).

Benefits are payable at 70 percent of allowable charges. Your share of the expenses does not count toward your coinsurance maximum. All procedures related to infertility must be preauthorized by Medi-Call.

The plan will not provide infertility benefits to a subscriber who has had a tubal ligation. **Prescription drugs for treatment of infertility are subject to a 30 percent coinsurance payment under both the Savings Plan and the Standard Plan.** This expense does not apply to the $2,500, per person, copayment maximum under the Standard Plan. It does apply to the Savings Plan deductible. The 70 percent plan payment for prescription drugs for infertility treatments does apply to both plans' $15,000 maximum lifetime benefit for infertility treatments. Call Medco's Member Services at 800-711-3450 for more information.

Inpatient Hospital Services

Inpatient hospital care, including room and board, is covered. In addition to normal visits by your physician while you are in the hospital, you are covered for one consultation per consulting physician for each inpatient hospital stay. **Inpatient care must be approved by Medi-Call. (See page 39 for more information.)**

Organ Transplants

State Health Plan (SHP) transplant contracting arrangements include the BlueCross BlueShield Association (BCBSA) national transplant network, Blue Distinction Centers for Transplants (BDCT). All BDCT facilities meet specific criteria that consider provider qualifications, programs and patient outcomes.

All transplant services must be approved by Medi-Call (see page 39). You must call Medi-Call even before you or a covered family member is evaluated for a transplant.

Through the BDCT network, SHP enrollees have access to the leading organ transplant facilities in the nation. Contracts are also in effect with local providers for transplant services so that individuals insured by the plan may receive transplants at those facilities. You will save a significant amount of money if you receive your transplant services either at a BDCT network facility or through a local South Carolina network transplant facility. If you receive transplant services at one of these network facilities, you will not be balance billed. You will be responsible only for your deductible, coinsurance and any charges not covered by the plan. In addition, these network facilities will file all claims for you.

Transplant services at nonparticipating facilities will be covered by the plan. However, the SHP will pay only the SHP allowable charges for transplants performed at out-of-network facilities. If you do **not** receive your transplant services at a network facility, you may pay substantially more. In addition to the deductible and coinsurance, subscribers using out-of-network facilities are responsible for any amount over the allowed charges and will pay an additional 20 percent in coinsurance, totaling 40 percent, because they used out-of-network providers.

Costs for transplant care can vary by hundreds of thousands of dollars. If you choose care outside the network, you cannot be assured that your costs will not exceed those allowed by the plan. Call Medi-Call for more information.

Outpatient Services

Outpatient services and supplies include:

- Laboratory services
- X-ray and other radiological services
- Emergency room services
- Radiation therapy
- Pathology services
- Outpatient surgery and
- Diagnostic tests (If the diagnosis is psychiatric, only services provided at APS network facilities are covered.).

For more information about the Standard Plan's per-occurrence deductibles, see page 32.

For more information about balance billing, see page 38.

If you are covered under the Standard Plan and you receive your outpatient services at a hospital, you will be charged a $75 outpatient per-occurrence deductible. You will be charged a $125 per-occurrence deductible for emergency room services. Per-occurrence deductibles do not apply to your annual deductible or your coinsurance maximum, which is waived if you are admitted to the hospital as an inpatient.

Where lab work is performed is a decision between you and your doctor. However, some medical and radiological laboratories are not in the network. If you use a provider who is not in the network, the provider may charge you more than the allowable charge, and you will be billed for the balance.

Some laboratory, X-ray and diagnostic tests are considered investigational or experimental and are therefore excluded by the plan. Call BlueCross BlueShield of South Carolina Customer Service for more information or to find out if a particular service is covered.

Pregnancy and Pediatric Care

Pregnancy benefits are provided to covered female employees or retirees and to covered dependent wives of male employees or retirees. **Dependent children do not have maternity benefits**. Maternity benefits include necessary prenatal and postpartum care, including childbirth, miscarriage and complications related to pregnancy. **You must call Medi-Call within the first three months of your pregnancy to enroll in the Maternity Management Program.** See page 40 for more information.

Under federal law, group health plans generally cannot restrict benefits for the length of any hospital stay in connection with childbirth for the mother or the newborn to fewer than 48 hours following normal, vaginal delivery or fewer than 96 hours following a caesarean section. Neither can they require a provider to obtain authorization from the plan for prescribing a length of stay within the above periods. The attending provider, may, however, in consultation with the mother, decide to discharge the mother or newborn earlier.

Pregnancy is not considered a pre-existing condition.

Prescription Drugs

Prescription drugs, including insulin, are covered at a participating pharmacy subject to plan exclusions and limitations. Drugs in FDA Phase I, II or III testing are not covered. Prescription medications associated with infertility treatments have a different coinsurance rate. Please refer to page 47 for more information.

Nonsedating antihistamines and drugs for treating erectile dysfunction are not covered under the Savings Plan.

Reconstructive Surgery After a Medically Necessary Mastectomy

The plan will cover, as required by the Women's Health and Cancer Rights Act of 1998, mastectomy-related services, including:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and
- Treatment of physical complications in all stages of mastectomy, including lymphedema.

These services apply only in postmastectomy cases, and all services must be approved by Medi-Call.

Rehabilitation Care

Rehabilitation care is subject to all terms and conditions of the plan including:

- Preauthorization is required for any inpatient rehabilitation care, regardless of the reason for the admission, and is required for any outpatient rehabilitation therapy that occurs after an inpatient admission for rehabilitation therapy
- The rehabilitation therapy must be performed in the most cost-effective setting appropriate to the condition
- The provider must submit a treatment plan to Medi-Call
- There must be reasonable expectation that sufficient function can be restored for the patient to live at home
- Significant improvement must continue to be made
- An inpatient admission must be to an accredited (JCAHO or CARF) rehabilitation facility.

Rehabilitation benefits are not payable for:

- Vocational rehabilitation intended to teach a patient how to be gainfully employed
- Pulmonary rehabilitation (except in conjunction with a covered and approved lung transplant)
- Behavior therapy, including speech therapy associated with behavior
- Cognitive (mental) retraining
- Community re-entry programs
- Long-term rehabilitation after the acute phase
- Work-hardening programs.

Rehabilitation – Acute
The plan provides limited rehabilitation benefits. Often acute-phase rehabilitation is done in an outpatient setting. In complex cases, the rehabilitation may be done in an acute-care facility and then a sub-acute rehabilitation facility or an outpatient facility. Acute rehabilitation begins soon after the start of the illness or injury and may continue for days, weeks or several months.

Rehabilitation – Long-term
Long-term rehabilitation refers to the point at which further improvement is possible, in theory, but progress is slow and its relationship to formal treatment is unclear. Long-term rehabilitation after the acute phase is generally not covered.

Second Opinion

If Medi-Call advises you to seek a second opinion before a medical procedure, the plan will pay 100 percent of the cost for that opinion. These procedures include surgery as well as treatment (including hospitalization). If APS Healthcare advises you to seek a second opinion before receiving treatment for mental health or substance abuse services, the plan will pay 100 percent of the cost for that opinion.

Skilled Nursing Facility

The plan will pay limited benefits for room and board in a skilled nursing facility for up to 60 days or $6,000, based on a per-day rate, whichever is less. Physician visits are limited to one per day. These services require approval by Medi-Call.

Speech Therapy

The plan covers short-term speech therapy to restore speech or swallowing function that has been lost as a result of disease, trauma, injury or congenital defect (e.g., cleft lip or cleft palate). Speech therapy must be prescribed by a physician and rendered by a licensed speech therapist.

Speech therapy requires preauthorization when provided in an inpatient setting or in a home setting. However, claims for speech therapy that are not preauthorized may be verified for medical necessity after the claim is submitted. These expenses are covered only if they are determined to be medically necessary and associated with a service allowed by the plan.

Maintenance therapy begins when the therapeutic goals of a treatment plan have been achieved or when no further functional progress is documented or expected to occur. Maintenance therapy is not covered.

Speech therapy is not covered when associated with any of the following:

- Language delay
- Communication delay
- Developmental delay
- Behavioral disorders
- Cognitive (mental) retraining
- Community re-entry programs or
- Long-term rehabilitation after the acute phase of treatment for the injury or illness.

After a claim is paid, BlueCross BlueShield of South Carolina can still review speech therapy services to determine if the services are a benefit covered by the plan. Please call Customer Service or Medi-Call before beginning the service if you need help in interpreting the list above.

Surgery

Physician charges for medically necessary inpatient surgery, outpatient surgery and use of surgical facilities are covered, if the care is associated with a service allowed by the plan.

Other Covered Expenses

These expenses are covered if they are determined to be medically necessary and associated with a service allowed by the plan:

- Blood and blood plasma, excluding storage fees
- Nursing services (part-time/intermittent)
- Dental treatments or surgery to repair damage from an accident, for up to one year from the date of the accident
- Dental surgery for bony, impacted teeth when supported by X-rays.

Extended care as an alternative to hospital care **only** if it is approved by Medi-Call.

PREVENTIVE BENEFITS

The Standard Plan and the Savings Plan have benefits that can help make it easier for you and your family to stay healthy. You also are eligible for Prevention Partners programs. By helping prevent potentially expensive health problems and hospital admissions, these benefits help control medical claims costs, saving you and the plan money.

Mammography Program for Women

Routine mammograms are covered at 100 percent as long as you use a participating facility and meet eligibility requirements.

- If you are age 35 through 39, one baseline mammogram (four-view) will be covered during those years.
- If you are age 40 through 74, one routine mammogram (four-view) a year will be covered.

For more information about staying healthy, see page 20 or log onto the EIP Web site at www.eip.sc.gov and click on "Prevention Partners."

Charges for routine mammograms performed at nonparticipating facilities are not covered, with the exception of procedures performed outside South Carolina. Non-network providers are free to charge you any price for their services, so you may pay more.

Preventive mammogram benefits are in addition to benefits for diagnostic mammograms. Any charges for additional mammograms are subject to deductibles and coinsurance.

For women, age 40 and older, covered as retirees and enrolled in Medicare, Medicare pays for one routine mammogram every year. The State Health Plan is primary for women covered as active employees, regardless of Medicare eligibility.

Pap Test Program

The plan will pay for a Pap test each year, without any requirement for a deductible or coinsurance, for covered women age 18 through 65. This benefit does not include the cost of the doctor's office visit or other lab tests.

WELL CHILD CARE BENEFITS

Well Child Care benefits are designed to promote good health and aid in the early detection and prevention of illness in children enrolled in the State Health Plan.

Who is Eligible?

Covered dependent children through age 18 are eligible for Well Child Care check-ups.

How Does it Work?

This benefit covers regular doctor visits and timely immunizations. When services are received from a doctor in the State Health Plan Physician Network, benefits will be paid at 100 percent. **Benefits will not be paid for services from non-network providers.** Some services may not be considered part of the Well Child Care. For example, if during a well child visit a fever and sore throat were discovered, the lab work to verify the diagnosis would not be part of the routine visit. These charges would be subject to deductible and coinsurance, as would any other medical expense.

Checkups

This is the schedule of regular checkups for which the plan pays 100 percent when a network doctor provides the services:

- Younger than 1 year old — five visits
- 1 year old — three visits
- 2 through 18 years old — one visit per year.

Immunizations

This schedule shows routine immunizations for which the plan pays 100 percent when a network doctor provides the services. To ensure that the immunization will be covered, the child must have reached the age at which the schedule says the immunization should be given.

If your covered child has delayed, or missed, receiving immunizations at the recommended times, the plan will pay for "catch-up" immunizations through age 18, for the vaccines listed, and subject to the limitation outlined above. Please contact your State Health Plan pediatrician or call Medi-Call for more information on how to immunize your child properly.

Disease	Recommended Immunization Schedule
Hepatitis B	Birth-2 months 1-4 months 6-18 months 11-12 years if has not had before
Polio	2 months 4 months 6-18 months 4-6 years
Diphtheria-Tetanus-Pertussis	2 months 4 months 6 months 15-18 months 4-6 years 11-12 years if none in last 5 years
Haemophilus (Hib)	2 months 4 months 6 months 12-15 months
Pneumococcal Conjugate (PCV7)	2 months 4 months 6 months 12-15 months
Measles-Mumps-Rubella	12-15 months 4-6 years 11-12 years if has not already had second dose
Chickenpox	12-18 months 11-12 years if has not already had disease or vaccine
Influenza	Yearly for healthy children ages 6 months-59 months Yearly for children with risk factors, ages 6 months-12 years
Meningococcal	11-12 years
Hepatitis A	12-23 months
Human Papillomavirus (HPV)	11-12 years for females

CARINGBRIDGE®: COMMUNICATION IN A CRISIS

CaringBridge® offers free, personalized Web sites that make it easier for you and your dependents to communicate with family and friends in a health crisis. To create a site, go to www.caringbridge.org and follow the directions. Creating a site does not require any technical expertise. Tell your family and friends about your site so they can keep up-to-date on your condition.

NATURAL BLUE AND OTHER DISCOUNT PROGRAMS

Natural Blue is a discount program available to State Health Plan subscribers. Offered by BlueCross BlueShield of South Carolina (BCBSSC), it provides holistic healthcare choices and information. The program has a network of licensed acupuncturists, massage therapists and fitness clubs that may be used at lower fees, often as much as a 25 percent discount. Natural Blue also offers discounts on health products, such as vitamins, herbal supplements, books and tapes.

Value-Added Benefits is a network of providers and suppliers that offer discounts on products and services that BCBSSC makes available but that are not State Health Plan benefits. Discounts are available on LASIK vision correction, hearing aids, cosmetic dentistry, cosmetic surgery, hair restoration, weight loss, allergy control and children's fitness.

Members may use their MoneyPlu$ funds tax free for LASIK, contacts, eyeglasses, hearing aids and many other services. For a complete listing of qualified medical expenses for MoneyPlu$ or the Health Savings Account is available at www.irs.gov/publications/p502/index.html.

For more information on Natural Blue or Value-Added Benefits, log on to the BCBSSC Web site at www.SouthCarolinaBlues.com. Under "Looking for...," select "Discounts and Added Values."

ADDITIONAL BENEFITS FOR SAVINGS PLAN PARTICIPANTS

As a participant in the Savings Plan, you are taking greater responsibility for your healthcare. To make that easier, your plan offers extra preventive benefits at no cost. They include:

- A yearly flu immunization for each eligible participant
- Access to the 24-hour Health at Home® Nurseline, through which registered nurses provide personal, immediate assistance to subscribers. The toll-free number is listed on the back of your health plan ID card and on the cover of the self-care handbook.
- A copy of the 416-page, full-color self-care handbook, *Health at Home®—Your Complete Guide to Symptoms, Solutions & Self-Care.*

Physical Exam

Savings Plan participants age 19 and older may receive from a network provider an annual physical in his office that includes:

- A preventive, comprehensive examination
- A complete urinalysis
- An EKG
- A fecal occult blood test
- A general health laboratory panel blood work
- A lipid panel once every five years.

Note: If your network physician sends tests to a non-network physician or laboratory, the tests will not be covered.

PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUGS – 800-711-3450

Prescription drugs are a major benefit to you and a major part of the cost of our self-insured health plan. Using generic drugs saves you and the plan money. You also can save money, and receive the same FDA-approved drugs, when you refill prescriptions through Medco by Mail, the mail-order prescription service. **Remember, benefits are paid only for prescriptions filled at network pharmacies or through the mail-order pharmacy.** Prescription drugs, including insulin or other self-injectable drugs (drugs administered at home), are covered subject to plan exclusions and limitations, provided you use a participating pharmacy. Drugs in FDA Phase I, II or III testing are not covered. Prescription medications associated with infertility treatments have a different coinsurance rate. Please refer to page 47 for more information.

Standard Plan

The prescription drug benefit, administered by Medco Health Solutions, Inc., is easy and convenient to use. With this program, you show your State Health Plan identification card when you purchase your prescriptions from a participating retail pharmacy and pay a copayment of $10 for tier 1 (generic – lowest cost) $25 for tier 2 (brand – higher cost) or $40 for tier 3 (brand – highest cost) for up to a 31-day supply. If the price of your prescription is less than the copayment, you pay the lesser amount.

A *copayment* is a fixed dollar amount a subscriber must pay for a covered expense in addition to what the insurance plan pays.

Prescription drug benefits are payable without an annual deductible. There are no claims to file. The prescription drug benefits are the same for the Standard Plan and the Medicare Supplemental Plan.

The prescription drug benefit has a separate annual copayment maximum of $2,500 per person. This means that after you spend $2,500 in prescription drug copayments, the plan will pay 100 percent of your allowable prescription drug charges for the remainder of the year.

Drug expenses do not count toward your medical annual deductible, coinsurance maximum or your lifetime maximum benefit.

Savings Plan

With this program, you show your State Health Plan identification card when you purchase your prescriptions from a participating retail pharmacy and pay the full allowable charge for your prescription drugs when you purchase them. There is no copayment.

This cost is transmitted electronically to BlueCross BlueShield of South Carolina. If you have not met your annual deductible, the full allowable charge for the drug will be credited to it. If you have met your deductible, you will be reimbursed for 80 percent of the drug's allowable charge. The remaining 20 percent of the cost will be credited to your coinsurance maximum.

Nonsedating antihistamines and drugs for erectile dysfunction are not covered under the Savings Plan.

My Rx Choices

My Rx Choices is an online tool that may help you and your doctor make more economical decisions about your long-term prescriptions. Go to www.medco.com and select *My Rx Choices*. You can search for the medications you take, learn what you will pay for them and find out how much you could save by using lower-cost alternatives that are available under your plan. Your options could include generic drugs, less expensive brand-name drugs or use of Medco's mail-order pharmacy, Medco by Mail.

You can ask your doctor to consider Medco's suggestions. If he thinks any of the alternative drugs are appropriate for you, he can write a new prescription.

Depending on the drugs you take and the alternatives available, a Medco pharmacist may be able to contact your doctor on your behalf. *However, no prescription will ever be changed without your doctor's approval, and you will be notified of the change.*

Generic Drugs (Tier 1 – Lowest Cost)

Under both plans, your prescription drug choices are divided into three categories: tier 1 (generic – lowest cost), tier 2 (brand – higher cost) and tier 3 (brand – highest cost).

Generic medications may differ in color, size or shape, but the FDA requires that the active ingredients be the chemical equivalent of the brand-name alternative and have the same strength, purity and quality. Prescriptions filled with generic drugs often have lower allowable charges, under the Savings Plan, and lower copayments, under the Standard Plan. Therefore, you get the same health benefits for less.

You may wish to ask your doctor to mark "substitution permitted" on your prescription. If he does not, your pharmacist will have no choice but to give you the brand-name drug, if that is the way the prescription is written.

"Pay-the-Difference" Policy

Under the State Health Plan, there is a "pay-the-difference" policy. This means if you purchase a brand-name drug when there is an equivalent generic drug available, the benefit will be limited to that for the generic drug. This policy will apply even if the doctor prescribes the medication as "Dispense As Written" or "Do Not Substitute."

Under the **Standard Plan,** if you purchase a brand-name drug over a generic, you will be charged the generic copayment, PLUS the difference between the allowable charge for the brand name and the generic drug. If the total amount is less than the preferred or non-preferred brand copayment, you will pay the brand copayment. Only the copayment for the generic drug will apply toward your copayment maximum.

Under the **Savings Plan**, if you purchase a brand-name drug over a generic, only the allowable charge for the generic drug will apply toward your deductible. After you have met your deductible, only the patient's 20 percent share of the allowable charge for the generic drug will apply toward your coinsurance maximum.

If you are taking a brand-name drug, you may wish to ask your doctor about using a generic drug, if one is available. If appropriate, the doctor may note on the prescription that substitution is permitted.

Tier 2 (Brand – Higher Cost)

These are medications that Medco's Pharmacy and Therapeutics Committee has determined to be safe, effective and available at a lower cost than tier 3 brand drugs. The list of tier 2 (preferred brand) medications may be updated throughout the year. It is available online at www.medco.com. You may reach the Medco Web site through the EIP Web site by clicking on the "Insurance Managers" link.

Tier 3 (Brand – Highest Cost)

These medications carry a higher copayment or higher price. All tier 3 drugs have an effective alternate option either as a tier 1 (generic) or as a tier 2 (brand) drug.

Compound Prescriptions

A compound prescription is a medication that requires a pharmacist to mix two or more drugs, based on a doctor's prescription, when such a medication is not available from a manufacturer. It is handled the same way any prescription is handled and must be purchased from a participating pharmacy.

Be sure to select a participating pharmacy that will file your compound prescription claim. If the pharmacy does not file for you, you must pay the entire cost of the prescription and then submit a claim to Medco. Information on how to file a claim to Medco is on page 223. Claims must be accompanied by an itemized list of the ingredients for you to be reimbursed. Ask your pharmacist to provide you with this list when you fill your prescription. Please be sure it includes:

- The name of each ingredient
- The valid National Drug Code (NDC) for each ingredient
- The quantity of each ingredient.

This information allows Medco to process your claim based on the actual ingredients in your medication.

When you file your own claim, your reimbursement may be less than what you paid for the drug because it will be limited to the plan's allowable charge minus the copayment for the actual ingredients in the compound prescription.

Some compound medications may be available through Medco by Mail. Please contact Medco to see if they are available before ordering.

Preauthorization

Some medications will be covered by the plan only if they are prescribed for certain uses. These drugs must be authorized in advance, or they will not be covered under the plan. If the prescribed medication must be preauthorized, you or your pharmacist may begin the review process by contacting Medco at 800-711-3450.

RETAIL PHARMACY

You must use a participating pharmacy, and you must show your health plan identification card when purchasing medications. The State Health Plan participates in Rx Selections®, Medco's pharmacy network. Most major pharmacy chains and independent pharmacies participate in this network. A list of network pharmacies is available through the EIP Web site, www.eip.sc.gov (Choose your category, then select "Online Directories") or at www.medco.com. You may also obtain a list of network pharmacies from your benefits administrator.

Retail Maintenance Network

If you are enrolled in the *Standard Plan* **or the** *Medicare Supplemental Plan***, you may buy 90-day supplies of prescription drugs at mail-order prices at local pharmacies belonging to the Retail Maintenance Network.** You will pay the same copayment as you would pay through mail order. This applies only to prescriptions filled for a 63-90 day supply at one of the pharmacies participating in the network. Copayments for prescriptions filled for a 0-62 day supply at these retail pharmacies will remain the same. The copayments will also remain the same at all other network pharmacies. To see a list of the pharmacies, go to the EIP Web site, www.eip.sc.gov, choose your category and select "Online Directories." If you do not have Internet access, ask your benefits administrator to print a copy of the list for you. For more information, call Medco Customer Service at 800-711-3450.

MAIL-ORDER PHARMACY

The Standard Plan and the Savings Plan offer mail-order service for 90-day supplies of prescriptions. By using this service, you receive a discount on the same FDA-approved prescription drugs that you would buy at a retail pharmacy.

Mail order is an ideal option for anyone with a recurring prescription, such as birth control medicine, or a chronic condition, such as asthma, high cholesterol or high blood pressure. Some controlled substances may not be available by mail order. Please call Medco customer service before submitting your prescription.

Because of state and federal regulations, some medications may only be dispensed in 31-day supplies. Drugs in this category include, but are not limited to, those used to treat pain, anxiety and sleep problems. Before you order a 90-day supply of a drug, call Medco at 800-711-3450 to be sure the drug is available in that quantity. If your prescription calls for a 90-day supply and the drug may not be dispensed in that amount, you will be charged for a 90-day supply but will be sent a 31-day supply.

Standard Plan

The copayments for up to a 90-day supply are: tier 1 (generic) – $25, tier 2 (brand) – $62, and tier 3 (brand) – $100.

Savings Plan

You pay the full allowable charge when you order prescription drugs through the mail. However, that cost for a 90-day supply will typically be less than you would pay at a retail pharmacy.

How to Order Drugs by Mail

This is how the mail-order service works:

- Ask your physician to write your prescription for a single 31-day supply and for a 90-day supply with refills.
- Fill your prescription for a 31-day supply at a participating retail pharmacy.
- Complete a mail-order prescription form and mail it to Medco. (Forms are available through the EIP Web site, www.eip.sc.gov, under "Forms" or on Medco's Web site: www.medco.com.)
- Your order will be processed and sent to your home, typically within 10-14 business days. Meanwhile, use your prescription from your retail pharmacy.

You may use the EZ REIMBURSE® Card, associated with the MoneyPlu$ Medical Spending Account, to order prescriptions through a plan's mail-order pharmacy. For more information on the EZ REIMBURSE® Card, see page 157.

Once the initial prescription has been entered and filled, you may order refills online or by phone using Medco's toll-free number: 800-711-3450.

If you want to save money by ordering a 90-day supply by mail, be sure to ask your doctor to write a prescription for a **90-day supply with refills**. Under the **Standard Plan,** prescriptions written for a 31-day supply with refills will be filled for a 31-day supply, and you will be charged the same copayment that is charged for a 90-day supply. Under the **Savings Plan**, you can buy less than a 90-day supply.

COORDINATION OF BENEFITS

The State Health Plan coordinates prescription drug benefits, as well as medical benefits. This ensures that if you are covered by more than one health plan, both plans pay their share of the cost of your care. See page 19 for more information.

EXCLUSIONS

Some prescription drugs are not covered under the plan. See page 54 for more information.

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

For Preauthorization – 800-221-8699

Claims for mental health and substance abuse are subject to the same deductibles, coinsurance and coinsurance maximums as medical claims. There is no limit on the number of provider visits allowed as long as the care is medically necessary. There is not a separate annual and lifetime maximum for mental health and substance abuse benefits.

All services (outpatient office visits, inpatient hospital admissions, etc.) must be preauthorized by APS Healthcare to be covered.

Here is how the SHP mental health and substance abuse program works:

- When you need care inside or outside South Carolina, call APS Healthcare, Inc., the behavioral health manager, at 800-221-8699 to receive preauthorization and to be directed to a network of providers. A *provider* is a physician, psychiatrist, health professional or institutional care provider under agreement to participate in the network administered by APS Healthcare.
- If you need inpatient care, you must call APS Healthcare for preauthorization or within 24 hours of an emergency admission.
- The provider network is open, which means that any eligible provider can participate. You may nominate providers for inclusion in the network. If you do not call APS Healthcare or if you choose to use a non-participating provider, no benefits will be paid.
- To review the network of providers, log on to the EIP Web site at www.eip.sc.gov, then choose your category and select "Online Directories," or go directly to www.apshealthcare.com. Once you are on APS' Web site, click on "Information for Members." Then select "State of South Carolina" from the drop down list under "EMPLOYERS." Click on "Online Provider Locator." You will need to enter the State Health Plan's access code, which is "statesc" (all lower case). Finally, click on "Submit."
- You will then be able to search the directory by either entering a provider's name or a geographic area. If you would like to view or download the directory, go back to the main South Carolina page and click on "Access the Printable Directory," then enter "statesc."

Paper copies of the provider directory are available from your benefits office or, if you are a retiree, survivor or COBRA subscriber, from APS customer service.

No Claims to File

There are no claims to file. Your network provider is responsible for submitting claims for these services. Remember, no benefits will be paid if you receive care from a provider who is not a member of the network. Your participating mental health and substance abuse provider will be required to conduct periodic medical necessity reviews (similar to Medi-Call). For claims or customer service assistance for mental health and/or substance abuse care, call APS Healthcare at 800-221-8699.

The Free & Clear® Quit For Life™ Program

The research-based Quit For Life Program is available at no charge to State Health Plan subscribers and their covered dependents.

One of the most successful programs of its kind, the Quit For Life Program helps participants stop using cigarettes, cigars, pipes and smokeless tobacco. A professionally trained Quit Coach™ works with each participant to create a personalized quit plan. As part of the 12-month program, participants receive Quit Guides and five telephone calls from a Quit Coach. A participant may call Free & Clear's toll-free support line as often as he wishes. The program also provides free nicotine replacement products (patches, gum or lozenges) if appropriate. Your Quit Coach may also recommend your doctor prescribe a smoking cessation drug, such as bupropion or Chantix, which are available through your prescription drug coverage. The sup-

port line is available from 8 a.m. to midnight, seven days a week. If the participant still needs help after the 12-month program ends, he may re-enroll in the program.

To enroll in the Quit For Life Program, call 866-QUIT-4-LIFE (866-784-8454). After your eligibility is verified, you will be transferred to a Quit Coach for your first call.

APS Helplink™

APS Helplink™ provides tools to help with behavioral health problems, financial and legal issues, child and eldercare concerns and work/life issues. Go to the APS Web site. Follow the instructions on page 58 that you use to get to the "Provider Locator," and then click on the "Access APSHelpLink" button. Enter the State Health Plan's "Company Code," which is "statesc."

EXCLUSIONS

Services Not Covered by the State Health Plan

There are some medical expenses the State Health Plan does not cover. The *Plan of Benefits* document (available in your benefits office or through EIP) contains a complete list of the exclusions. Some expenses that are not covered are charges for:

1. Services or supplies that are not medically necessary
2. Routine procedures not related to the treatment of injury or illness, except for those specifically listed under the Preventive Screenings
3. Services related to a pre-existing condition in the first 12 months of coverage (or 18 months for late entrants). This may be reduced by any creditable coverage you bring to the plan
4. Routine physical exams, checkups (except Well Child Care and Preventive Screenings according to guidelines), services, surgery (including cosmetic surgery) or supplies that are not medically necessary. (Please note: The Savings Plan covers an annual physical by a network physician for each participant age 19 and older)
5. Eyeglasses
6. Contact lenses, unless medically necessary after cataract surgery and for the treatment of keratoconus, a corneal disease affecting vision
7. Routine eye examinations
8. Refractive surgery, such as radial keratotomy, laser-assisted in situ keratomileusis (LASIK) vision correction, and other procedures to alter the refractive properties of the cornea
9. Hearing aids and examinations for fitting them
10. Dental services, except for removing impacted teeth or treatment within one year of a condition resulting from an accident
11. TMJ splints, braces, guards, etc. (Medically necessary surgery for TMJ is covered if preauthorized by Medi-Call.) TMJ, temporo mandibular joint syndrome, is often characterized by headache, facial pain and jaw tenderness caused by irregularities in the way joints, ligaments and muscles in the jaws work together
12. Custodial care, including sitters and companions or homemakers/caretakers
13. Over-the-counter medicine and contraceptive devices
14. Services related to a vasectomy or tubal ligation performed within one year of enrollment
15. Surgery to reverse a vasectomy or tubal ligation
16. Treatment for infertility resulting from a previous tubal ligation or vastectomy
17. Assisted reproductive technologies (fertility treatment) except as noted on page 47 of this chapter
18. Diet treatments and all weight loss surgery, including, but not limited to: gastric bypass, gastric banding or stapling; intestinal bypass and any related procedures; the reversal of such procedures; and conditions and complications as a result of such procedures or treatment

19. Equipment that has a nontherapeutic use (such as humidifiers, air conditioners, whirlpools, wigs, artificial hair replacement, vacuum cleaners, home and vehicle modifications, fitness supplies, speech augmentation or communication devices, including computers, etc.), regardless of whether the equipment is related to a medical condition or prescribed by a physician
20. Air quality or mold tests
21. Supplies used for participation in athletics (that are not necessary for activities of daily living), including but not limited to, splints or braces
22. Physician charges for medicine, drugs, appliances, supplies, blood and blood derivatives, unless approved by Medi-Call
23. Medical care by a doctor on the same day or during the same hospital stay in which you have surgery, unless a medical specialist is needed for a condition the surgeon could not treat
24. Physician's charges for clinical pathology, defined as services for reading any machine-generated reports or mechanical laboratory tests. The interpretation of these tests is included in the allowance for the lab service
25. Fees for medical records and claims filing
26. Food supplements, including but not limited to formula, enteral nutrition, Boost/Ensure or related supplements
27. Services performed by members of the insured's immediate family
28. Acupuncture
29. Chronic pain management programs
30. Transcutaneous (through the skin) electrical nerve stimulation (TENS), whose primary purpose is the treatment of pain
31. Complications arising from the receipt of noncovered services
32. Psychological tests to determine job, occupational or school placement or for educational purposes; milieu therapy; or to determine learning disability
33. Services or supplies payable by Workers' Compensation, the Veterans Administration or any other governmental or private program (including Employee Assistance Program services)
34. Charges for treatment of illness or injury or complications caused by acts of war or military service, injuries received by participating in a riot, insurrection, felony or any illegal occupation (job)
35. Intentionally self-inflicted injury that does not result from a medical condition or domestic violence
36. Cosmetic goods, procedures or surgery or complications resulting from such procedures or services
37. Nicotine patches used in smoking cessation programs, as well as prescribed drugs used to alleviate the effects of nicotine withdrawal, except as authorized for eligible participants enrolled in the Free & Clear® tobacco cessation program
38. Vocational rehabilitation, pulmonary rehabilitation (except in conjunction with a covered and approved lung transplant), behavior therapy, including speech therapy associated with behavior, cognitive (mental) retraining, community re-entry programs or long-term rehabilitation after the acute phase of treatment for the injury or illness (See Rehabilitation Care on page 49 and Speech Therapy on page 50)
39. Sclerotherapy (treatment of varicose veins), including injections of sclerosing solutions for varicose veins of the leg, unless a prior-approved ligation (tying off of a blood vessel) or stripping procedure has been performed within three years and documentation submitted to Medi-Call with a preauthorization request establishes that some varicosities (twisted veins) remained after the procedure
40. Animals trained to aid the physically challenged
41. Abortions, except for an abortion performed in accordance with federal Medicaid guidelines
42. Pregnancy of a covered dependent child
43. Speech therapy for the treatment of a language/communication or developmental delay (See page 50)
44. Storage of blood or blood plasma
45. Experimental or investigational surgery or medical procedures, supplies, devices or drugs.
    Any surgical or medical procedures determined by the medical staff of the third-party administrator with appropriate consultation, to be experimental or investigational or not accepted medical practice. Experimental or investigational procedures are those medical or surgical procedures, supplies, devices, or drugs, which at the time provided, or sought to be provided:

- Are not recognized as conforming to accepted medical practice in the relevant medical specialty or field of medicine; or
- The procedures, drugs or devices have not received final approval to market from appropriate government bodies; or
- Are those about which the peer-reviewed medical literature does not permit conclusions concerning their effect on health outcomes; or
- Are not demonstrated to be as beneficial as established alternatives; or
- Have not been demonstrated, to a statistically significant level, to improve the net health outcomes; or
- Are those in which the improvement claimed is not demonstrated to be obtainable outside the investigational or experimental setting.

Additional exclusions under the Savings Plan:

- Chiropractic benefits, under the Savings Plan only, are limited to $500 per covered person after the annual deductible is met.
- Nonsedating antihistamines and drugs for treating erectile dysfunction are not covered under the Savings Plan.

APPEALS

WHAT IF MY CLAIM OR REQUEST FOR PREAUTHORIZATION IS DENIED?

The Employee Insurance Program contracts with claims processors, BlueCross BlueShield of South Carolina, Medco Health Solutions, Inc., and APS Healthcare, Inc., to handle claims for your State Health Plan benefits. You have the right to appeal their decisions. This is how to do it:

If all or part of your claim or your request for preauthorization is denied, you will be informed of the decision promptly and told why it was made. If you have questions about the decision, check the information in this book, or call the company that made the decision for an explanation.

If you believe the decision was incorrect, you may ask the company to re-examine its decision. This request should be in writing and should be made within six months after notice of the decision. You (or your physician, on your behalf) may submit any additional information you wish to support this appeal. If you wait too long, the original decision will be considered final, and you will not have any further appeal rights. To begin an appeal, follow the instructions in your denial letter.

If you are still dissatisfied after the decision is re-examined, you may ask the Employee Insurance Program (EIP) to review the matter by making a written request to EIP within 90 days of notice of the denial. If the denial is upheld by EIP, you have 30 days to seek judicial review in the S.C. Administrative Law Court pursuant to S.C. Code Ann. 1-23-380, as amended on July 1, 2006.

Health Maintenance Organizations

WHAT ARE MY CHOICES?

Traditional HMO Plans

Traditional Health Maintenance Organizations (HMOs) are health plans in which subscribers must use only healthcare providers, including hospitals, within the HMO's network. If you receive care outside this network, the plan will not pay benefits unless the care was preauthorized or deemed an emergency. You must choose a Primary Care Physician (PCP) who coordinates your healthcare. To receive benefits when you see a specialist, you must first receive a referral from your PCP. Traditional HMOs available to you through the Employee Insurance Program (EIP) are **BlueChoice HealthPlan** and **CIGNA HealthCare.**

Point of Service (POS) Plan

A Point of Service (POS) Plan allows you to go to providers inside or outside its network. To receive the maximum level of benefits, care must be obtained from providers, including hospitals, within the network and be authorized by the third-party claims processor. When you use out-of-network providers, you will probably have much higher out-of-pocket expenses in the form of deductibles and copayments. The only POS plan offered is **MUSC Options**, which is available only in Berkeley, Charleston, Colleton and Dorchester counties.

Plan Descriptions

The HMOs are described in this section of the chapter. If you would like to use specific physicians, hospitals and other providers, you may wish to check to see if they are part of the network of the plan you are considering. You can only receive benefits if your provider is part of your HMO's network.

Refer to pages 208-213 for premiums and a comparison of benefits. For more information, active employees should contact their benefits administrator, the HMO or EIP. Retirees, COBRA subscribers and survivors should contact the HMO or EIP. Telephone numbers and Web sites are listed on the inside covers of this book.

HMO SERVICE AREAS

	COUNTIES	HMO CHOICES
1	Anderson, Greenville, Oconee, Pickens	BlueChoice, CIGNA
2	Cherokee, Spartanburg, Union	BlueChoice, CIGNA
3	Chester, Lancaster, York	BlueChoice, CIGNA
4	Abbeville, Greenwood, Laurens, McCormick, Saluda	BlueChoice
5	Fairfield, Kershaw, Lexington, Newberry, Richland	BlueChoice, CIGNA
6	Aiken, Barnwell, Edgefield	BlueChoice
7	Allendale, Bamberg, Calhoun, Orangeburg	BlueChoice, CIGNA
8	Clarendon, Lee, Sumter	BlueChoice, CIGNA
9	Chesterfield, Darlington, Dillon, Florence, Marion, Marlboro, Williamsburg	BlueChoice, CIGNA
10	Georgetown, Horry	BlueChoice, CIGNA
11	Berkeley, Charleston, Colleton, Dorchester	BlueChoice, CIGNA, MUSC Options
12	Beaufort, Hampton, Jasper	BlueChoice, CIGNA

BlueChoice HealthPlan

BlueChoice HealthPlan is a traditional HMO offered statewide.

With BlueChoice HealthPlan, you select a Primary Care Physician (PCP) to coordinate your healthcare. If you need services your PCP does not offer, he or she will refer you to a qualified specialist in the network.

BlueChoice HealthPlan offers a wide range of programs designed to keep you healthy. Preventive care is a key feature of the plan. As a member, you simply pay a small copayment for well child visits and immunizations, as well as for any primary care visit.

BENEFITS AT A GLANCE

To be covered, services must be provided by your Primary Care Physician (PCP) or authorized in advance by your PCP and BlueChoice HealthPlan, unless otherwise noted. The *Plan of Benefits* governs all health benefits offered through EIP.

BENEFITS	MEMBER PAYS
Deductible per Calendar Year	
Per member	$250
Per family	$500
Coinsurance Maximum per Calendar Year	
Per member	$1,500
Per family	$3,000
Lifetime Benefit Maximum - $1,000,000	
Primary Care Physicians	
Office services, including routine and preventive care	$15 Copayment per visit
Hospital services	$0
Routine mammogram	$0
Specialty Care Physicians	*All services must be preauthorized*
Office services	$30 Copayment per visit
Maternity care	$30 Copayment first visit, then 10%
Hospital services	Deductible, then 10%
Emergency room care	Deductible, then 10%
Routine GYN exam - two per calendar year	$15 Copayment per visit *(Authorization not required)*
Chiropractic care - $1,000 maximum per calendar year	$30 Copayment per visit
Facility Services	*All services, except emergency, care must be preauthorized*
Inpatient admission	$200 Copayment per admission, then 10%
Skilled nursing facility and/or Long-term acute care facility - 120-day maximum per calendar year	Deductible, then 10%
Outpatient services/Ambulatory surgical centers	$100 Copayment and 10% for first 3 visits per calendar year; 10% for visit 4 and each visit thereafter
Emergency room services	$125 Copayment per visit, then 10%
Urgent Care	
Inside the local service area	$35 Copayment per visit at a participating urgent care provider
Prescription Medication	
Retail copayment *(up to a 31-day supply)*	$7 Generic drug $35 Preferred brand-name drug $55 Nonpreferred brand-name drug
Mail-order copayment *(up to a 90-day supply)*	$14 Generic drug $70 Preferred brand-name drug $110 Nonpreferred brand-name drug
Specialty Pharmaceuticals	$100 Copayment per 31-day supply

BENEFITS	MEMBER PAYS
Routine Vision Care - Physicians Eyecare Network (PEN) Providers Only (Refer to Provider Directory)	
One routine eye exam for eyeglasses per calendar year	$0
One pair of eyewear from a designated selection every other calendar year *(other discounts and/or fees will apply to glasses and contact lenses outside of the designated selection)*	$0
Fitting exam for contact lenses per calendar year	$45
Other Services	*All services, except emergency care, must be preauthorized*
Ambulance	Deductible, then 10%
Hospice	Deductible, then 10%
Medical supplies	Deductible, then 10%
Initial prosthetic appliances	Deductible, then 10%
Outpatient private duty nursing and home health	Deductible, then 10%
Dental services due to accidental injury	Deductible, then 10%
$500 maximum per calendar year	
Durable medical equipment (DME)	Deductible, then 10%
$5,000 maximum per calendar year	
Human Organ Transplants	
Lifetime Transplant Maximum	$350,000
Covered Transplants:	Maximum benefit per transplant:
Kidney (single)	$60,000
Pancreas/kidney	$80,000
Heart	$120,000
Lung (single)	$130,000
Lung (double)	$350,000
Liver	$225,000
Pancreas	$80,000
Heart/lung	$175,000

PRIMARY CARE PHYSICIAN

At enrollment, you must select a Primary Care Physician (PCP) from BlueChoice HealthPlan's network. Your PCP coordinates all health services covered under your plan. Each member of your family may select a different PCP. When you need to see a specialist or other healthcare professional, your PCP will refer you to a network provider. BlueChoice HealthPlan will cover those healthcare services according to this Plan of Benefits.

If you receive care from a specialist without a referral from your PCP, BlueChoice Health Plan will cover the services only if they are related to a medical emergency.

You may change your PCP at any time by calling Member Services at 800-868-2528 or visiting the BlueChoice Web site at www.BlueChoiceSC.com.

NETWORK BENEFITS

With BlueChoice HealthPlan, you receive benefits for covered services only when you go to participating (network) physicians, hospitals and other healthcare providers. Network providers will:

- File covered expense claims for you
- Ask you to pay only the deductible, copayment and/or coinsurance (if any) for covered expenses
- Accept the plan's payment for covered expenses as payment-in-full, minus any copayment or coinsurance due.

Referrals

Should you need medical care your PCP cannot provide, he or she will refer you to another network provider. Remember, to ensure that BlueChoice HealthPlan will pay for the visit to the specialist, make sure your doctor has made the referral before you visit the specialist. You can check for referrals on the BlueChoice Web site at www.BlueChoiceSC.com.

Note: Women may go to a participating gynecologist twice a year without a referral from their PCP. Women may also go to any participating obstetrician for prenatal care.

Finding a Network Provider

A complete list of providers is at www.BlueChoiceSC.com. If you would like a copy of the Provider Directory, you may request one by calling Member Services at 800-868-2528. You may also ask Member Services for more information about providers, including their qualifications and experience. Member Services can give you the most up-to-date information about changes in providers and about which ones are accepting new patients.

Deductibles

A deductible is the amount you must pay each year before the plan begins to pay certain benefits. BlueChoice HealthPlan's annual deductible is $250 for individuals and $500 for families.

The deductible does not apply to:

- Any services from your PCP, such as office visits, routine physicals and well child care and immunizations
- Office visits to specialists
- Retail and mail-order pharmacy benefits
- Specialty drugs
- Routine mammograms.

Coinsurance

Coinsurance is the percentage of the cost of certain services that you pay. As a BlueChoice HealthPlan member, you pay 10 percent of the cost of these services. Please see the Schedule of Benefits for more information. After you spend either $1,500 (individual coverage) or $3,000 (family coverage) in coinsurance for network services in a calendar year, the plan will pay 100 percent of your medical costs for network services for the remainder of the calendar year, excluding appropriate copayments. Copayments do not count toward your out-of-pocket coinsurance limit or your deductible.

Copayments

A copayment is the fixed dollar amount you pay when you receive a service. The copayment will vary depending on the type of care you receive. Your annual deductible does not affect copayments. You must make your copayments whether or not you have met your deductible.

COVERED SERVICES

To be covered, services must be provided by your PCP or by another network provider. Services provided by another network provider must be authorized in advance by your PCP and by BlueChoice HealthPlan, unless it is a medical emergency or otherwise noted in the Schedule of Benefits.

Ambulance Services

Charges for emergency ambulance transportation provided by a licensed ambulance service to the nearest hospital where emergency covered services can be rendered are covered. Coverage includes transportation between acute care facilities when a medically indicated transfer is needed.

Behavioral Health Services

You are covered for treatment of mental health conditions and substance abuse. Companion Benefit Alternatives (CBA) coordinates benefits for these services. To receive services from a mental health or substance abuse professional, you or your primary care physician may contact CBA at 800-868-1032 for authorization and/or more information. Services provided at a residential treatment center are not covered.

Chiropractic Care

You are covered for office services from a chiropractor, including detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and the effects of such nerve interference, where such interference is the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column. Diagnostic X-rays are covered if medically necessary. Other services that are within the scope of the practice of chiropractic are also covered.

Dental Services for Accidental Injuries

You are covered for dental services performed by a Doctor of Dental Surgery (DDS) or a Doctor of Medical Dentistry (DMD) to sound natural teeth when required because of accidental injury. For purposes of this benefit, an accidental injury is defined as an external traumatic force such as a car accident or blow by a moving object. The first (emergency) visit to the dentist does not require authorization. However, the dentist must submit an outline of the plan for future treatment to BlueChoice HealthPlan for review and approval before continuing with follow-up care in order for that care to be covered. Follow-up care must be completed within six months of the accident.

Doctor Visits

Charges from your PCP for office visits, including routine examinations, vision and hearing screenings, preventive care, injections, immunizations, well-child care and health education, are covered. Charges from specialists for treatment or consultation are also covered.

Durable Medical Equipment

Charges for medically necessary durable medical equipment, such as wheelchairs, braces, hospital beds, traction equipment, inhalation therapy equipment and suction machines, and other equipment as approved by BlueChoice HealthPlan for outpatient use, are covered. Equipment is covered only when ordered, delivered and used while you are enrolled with BlueChoice HealthPlan. *Durable medical equipment is not covered out of network.*

Repair, replacement or duplicates of durable medical equipment are not covered, except when medically necessary due to a change in your medical condition. Appliances that serve no medical purpose and are solely for your comfort, such as a whirlpool bath, air conditioner or dehumidifier, are not covered.

Emergency Services and Urgent Care

Emergency Services
You are covered for treatment of a true medical emergency anywhere in the world. If practical, you should call your PCP first and follow his or her directions. However, in a serious medical emergency, go to the nearest hospital or treatment center for help or call 911. You should then have someone notify your doctor and BlueChoice HealthPlan.

BlueChoice HealthPlan will cover emergency room care only if you are seeking treatment for symptoms that are severe and need immediate medical attention, or if your doctor authorized the emergency room visit. Conditions that are considered a medical emergency include those so severe that if you do not get immediate medical attention, one of the following could occur:

- Severe risk to your health, or with respect to pregnancy, the health of your unborn child
- Serious damage to body function
- Serious damage to any organ or body part.

For more information about receiving emergency services outside the BlueChoice HealthPlan service area, please review the section on the BlueCard® program on page 36.

Follow-up care for emergency services must be received from providers within the BlueChoice HealthPlan network or arranged by BlueChoice HealthPlan.

Urgent Care
Urgent care is a medical condition that is serious but not life- or limb-threatening. If you need urgent care, you should call your PCP. If you have an illness or injury that requires urgent care and you cannot get to your doctor or wait until normal business hours, you should go to a participating urgent care center. Please refer to the BlueChoice HealthPlan Provider Directory for the list of participating urgent care centers.

Urgent care required within South Carolina is covered when provided by a participating urgent care provider. Urgent care required outside South Carolina is covered when coordinated through the BlueCard program.

Hospice

You are covered for hospice care provided by a licensed hospice.

Human Organ Transplant Services

You are covered for certain human organ transplants. The organ must be provided from a human donor to you (the transplant recipient) and provided at a designated transplant facility. All solid organ (complete organ or segmental, cadaveric or living donor) procurement services, including donor organ harvesting, typing, storage and transportation, are covered.

Coverage for charges incurred by a living donor are limited to those for medical and surgical expenses for care and treatment, but only if the donor and recipient are both covered by the Employee Insurance Program.

Transplants that are experimental, investigational or unproven are not covered. Transplants that are not determined by BlueChoice HealthPlan to be medically necessary are also not covered.

Inpatient Hospital Services

You are covered for inpatient hospital services at an acute care hospital, a skilled nursing facility, or a long-term acute care hospital, including room and board, physician visits and consultations.

Maternity Care

You and your dependent spouse are covered for hospital care, hospital-based birthing center care, and prenatal and postpartum care, including childbirth, miscarriage and complications related to pregnancy. Inpatient benefits are provided for the mother and newborn for 48 hours after normal delivery, not including the day of delivery, or 96 hours after Caesarean section, not including the day of surgery. Coverage for the newborn includes, but is not limited to, routine nursery care and/or routine well-baby care during this period of hospital confinement. Charges for home births are not covered. Pregnancy is not considered a pre-existing condition.

Medical Supplies

Charges are covered for medical supplies, including, but not limited to:

- Dressings requiring skilled application, for conditions such as cancer or burns
- Catheters
- Colostomy bags and related supplies
- Medically necessary supplies for renal dialysis equipment or machines
- Surgical trays
- Splints or such supplies as needed for orthopedic conditions
- Syringes, test tapes and other related diabetic supplies not covered under other provisions of the plan.

Outpatient Hospital Services, Including Ambulatory Surgical Centers

Charges for outpatient laboratory, X-ray, surgery, and diagnostic tests are covered. Physical therapy, occupational therapy and speech therapy are also covered, subject to the limits listed in the Schedule of Benefits.

Outpatient Private Duty Nursing Care and Home Health Services

You are covered for special or private duty nursing care provided by a registered nurse or a licensed practical nurse, on an outpatient basis, for up to 60 days each calendar year. Services must be provided in lieu of inpatient care.

You are also covered for home health services provided by a licensed home health agency. Services must be provided in lieu of inpatient care.

Prescription Medicine

Prescription drugs, including insulin, are covered, subject to plan exclusions and limitations, if you use a participating pharmacy. You may purchase up to a 31-day supply of a covered prescription medication at a participating retail pharmacy and up to a 90-day supply through a participating mail-order pharmacy. Not all medications are available through the mail-order pharmacy. Please refer to the BlueChoice HealthPlan Preferred Drug List for a list of prescription drugs covered under your pharmacy benefits.

Generics Now[sm†]
Generic drugs are equivalent in composition and effect to their brand-name counterparts but are generally less expensive. BlueChoice HealthPlan has implemented a program called "Generics Now" to encourage the use of generic drugs. If your doctor prescribes a brand-name drug but allows you to substitute an equivalent generic drug if one is available, you should consider buying the generic drug. Here is why – if you request the brand-name drug over the generic drug, you will be required to pay the difference between the cost of the brand-name drug and the generic drug. You will also have to pay the copayment for the brand-name drug. However, you will never be charged more than the retail cost of the brand-name drug.

Specialty Pharmaceuticals
Specialty pharmaceuticals are prescription drugs used to treat complex clinical conditions with complex delivery of care and distribution requirements. They include, but are not limited to, infusible specialty drugs for chronic disease, injectable and self-injectable specialty drugs for acute and chronic disease, and specialty oral drugs. Specialty pharmaceuticals are covered when purchased from a designated participating provider and prescribed by a participating physician. You may obtain a list of specialty pharmaceuticals by contacting BlueChoice HealthPlan Member Services at 800-868-2528 (803-786-8476 in the Columbia area).

Prior Authorization
Certain prescription drugs require prior authorization in order to be covered, and certain drugs have dosage limits as determined by BlueChoice HealthPlan. Please refer to the BlueChoice HealthPlan Preferred Drug List for information on which drugs require prior authorization and/or have dosage limits.

Prosthetics

You are covered for a prosthetic device, other than a dental or cranial prosthetic, that is a replacement for a body part and meets minimum specifications. Only the initial prosthesis is covered.

Reconstructive Surgery after a Medically Necessary Mastectomy

If you are receiving benefits in connection with a mastectomy and/or elective breast reconstruction in connection with the mastectomy, you are covered for mastectomy-related services including:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications during all stages of mastectomy, including lymphedemas.

This coverage is in compliance with the Women's Health and Cancer Rights Act of 1998.

Rehabilitation Services

Benefits are provided for physical therapy, occupational therapy and speech therapy. Benefits are limited to 20 visits per benefit period for each type of therapy.

Therapeutic Services

Charges for radiation therapy, cancer chemotherapy and respiratory therapy are covered.

Vision Services

You are covered for one comprehensive vision examination each calendar year to determine the need for corrective eyeglass lenses. A member of the Physicians Eyecare Network must perform the exam. Additional charges for a contact lens examination and contact lens fitting are not covered.

You are covered for one pair of eyeglasses from a designated selection of lenses and frames from a member of the Physicians Eyecare Network every other calendar year. If you prefer contact lenses, the eyeglass benefit may be used as a credit toward a contact lens package. No other vision or eye examination is covered unless determined to be medically necessary to treat a medical condition and preauthorized by your PCP and BlueChoice HealthPlan.

For a list of Physicians Eyecare Network providers, please visit the BlueChoice HealthPlan Web site at www.BlueChoiceSC.com or refer to your Provider Directory.

EXCLUSIONS AND LIMITATIONS

No benefits are provided for the following, unless otherwise specified in the Schedule of Benefits or the Covered Services section.

1. Any services or supplies that are not medically necessary
2. Any services or supplies for which you are not legally obligated to pay
3. Any services or supplies for treatment of military service-related disabilities when you are legally entitled to other coverage and for which facilities are reasonably available to you
4. Any services or supplies for which benefits are paid under Workers' Compensation, occupational disease law or similar legislation
5. Treatment of an illness contracted or injury sustained while engaged in the commission of or attempt to commit an assault or a felony; treatment of an injury or illness incurred while engaged in an illegal act or occupation (job); or treatment of an injury or illness due to voluntary participation in a riot or civil disorder

6. Any charges for services provided before your effective date or after termination of coverage
7. Admissions or portions thereof for sanitarium care, rest cures or custodial care
8. Any services or procedures for transsexual surgery or related services provided as a result of complications of such transsexual surgery
9. All services and supplies related to pregnancy of a dependent child (Complication of pregnancy is covered. However, abortion is not considered a complication of pregnancy)
10. Services, supplies or drugs for the treatment of infertility, including, but not limited to, artificial insemination and in vitro fertilization, fertility drugs, reversal of sterilization procedures and surrogate parenting
11. Preconception testing, preconception counseling or preconception genetic testing
12. Any drugs, services, treatment or supplies determined by the medical staff of BlueChoice HealthPlan to be experimental, investigational or unproven
13. Drugs for which there is an over-the-counter equivalent; all vitamins, except prenatal vitamins; drugs not approved by the Food and Drug Administration; drugs for non-covered therapies, services or conditions; and drugs prescribed for obesity or weight control, cosmetic purposes, hair growth, fertility or for smoking cessation, except in conjunction with the Free and Clear®†† Quit for Life™ Program
14. Plastic or cosmetic surgical procedures or services performed to improve appearance or to correct a deformity without restoring a bodily function, unless such services are medically necessary and due to physical trauma, surgery or congenital anomaly (birth defect)
15. Therapy or services for learning disabilities, speech delay, stuttering, perceptual disorders, mental retardation, behavioral disorders, vocational rehabilitation or marriage counseling
16. Any drugs, services, treatment or supplies for the diagnosis or treatment of sexual dysfunction unless medically necessary for the treatment of a medical condition or organic disease, and then only with prior authorization. This includes, but is not limited to, drugs, laboratory and X-ray tests, counseling, and penile implants or prostheses
17. Services or supplies related to dysfunctional conditions of the muscles of mastication; malpositions or deformities of the jaw bone(s); and orthognathic deformities or temporomandibular joint (TMJ) disorders, including, but not limited to, appliances and orthodontia
18. Dental work or treatment that includes hospital or professional care in connection with:
    a. Any operation or treatment for the fitting or wearing of dentures, regardless if needed due to injury to natural teeth due to an accident
    b. Orthodontic care or treatment of malocclusion
    c. Operations on, or treatment of or to, the teeth or supporting bones and/or tissues of the teeth, except for removal of malignant tumors or cysts or treatment of an injury to natural teeth due to an accident
    d. Removal of teeth, whether impacted or not
    e. Any operation, service, prosthesis, supply or treatment for the preparation for, and the insertion or removal of, a dental implant

    This exclusion does not apply if the dental work involves facility or anesthesia services that are medically necessary because of a specific organic medical condition, such as congestive heart failure or chronic obstructive pulmonary disease, that requires hospital-level monitoring
19. Hearing aids
20. Charges incurred as the result of a missed scheduled appointment and charges for the preparation, reproduction or completion of medical records, itemized bills or claims forms
21. Services or supplies not specifically listed in the Schedule of Benefits and the Covered Services section
22. Transplants other than as specified in the Schedule of Benefits
23. Complications arising during, from or related to the receipt of non-covered services. "Complications," as used in this exclusion, includes any medically necessary services or supplies which, in BlueChoice HealthPlan's judgment, would not have been required by you had you not received non-covered services

24. The purchase or rental of air conditioners, air purifiers, motorized transportation equipment, escalators or elevators, swimming pools, water beds, exercise equipment or other similar items or equipment
25. Any service or supply provided by a member of your family or by yourself, including the dispensing of drugs. A member of your family means your spouse, parent, grandparent, brother, sister, child or your spouse's parent
26. Charges for acupuncture, hypnotism, biofeedback and TENS unit. Services for chronic pain management programs or any program developed by centers with multidisciplinary staffs intended to provide the interventions necessary to allow you to develop pain-coping skills and freedom from dependence of analgesic medications
27. Treatment with respect to a specific condition for which a person refused to comply with a physician's prescribed course of treatment, or complications that arise from failure to follow the physician's prescribed course of treatment
28. Services not provided by or under the direction of your Primary Care Physician, except covered services or referred services authorized in advance by BlueChoice HealthPlan
29. Treatment or surgery for obesity, morbid obesity, weight reduction or weight control, including, but not limited to, gastric bypass or stapling, intestinal bypass and related procedures, the reversal of such procedures, and services required as a result of complications from such procedures including reconstructive procedures necessitated by weight loss
30. Orthomolecular therapy, including infant formula, nutrients, vitamins and food supplements.
31. Radial keratotomy, myopic keratomileusis, LASIK surgery, and any surgery that involves corneal tissue for the purpose of altering, modifying or correcting vision problems such as myopia, hyperopia or stigmatic error
32. Treatment of weak, strained or flat feet, including orthopedic shoes or other supportive devices; for services and supplies for non-surgical treatment of the feet; and cutting, removal or treatment of corns, calluses or nails. This exclusion does not include corrective surgery, or treatment for metabolic or peripheral vascular disease
33. Nutrition counseling, lifestyle improvements and physical fitness programs
34. Communications, travel time and transportation, except for professional ambulance services
35. Cranial orthotics used on infants with misshapen heads to progressively mold the skull to a normal shape
36. Sclerotherapy, including injections of sclerosing solution for varicose veins of the leg, unless a prior covered ligation or stripping procedure was performed within three years and documentation establishes that some varicosities remained after the prior procedure
37. Growth hormone therapy for patients over 18 years of age. Growth hormone therapy for patients age 18 and younger with documented growth hormone deficiency is covered
38. Pulmonary rehabilitation, except in conjunction with a covered lung transplant
39. Any procedures, drugs, treatment or services for or related to an elective abortion
40. Charges for services or supplies from an independent healthcare professional whose services are normally included in facility charges.

OTHER PLAN FEATURES

Away From Home Care

Any time you or one of your family members will be out of South Carolina for more than 90 days, you can become a guest member of an affiliated BlueCross and BlueShield health plan near your destination. Just call BlueChoice HealthPlan and explain your situation. Students and long-term travelers are two groups that can benefit from Away From Home Care. If you need to use the Away From Home Care program, call Member Services at 800-868-2528 (803-786-8476 in the Columbia area) and ask to speak to the Away From Home Care program coordinator, or visit www.BlueChoiceSC.com for more information.

Great Expectations®† *for health*

As your partner in good health, one way BlueChoice HealthPlan can help you reach your health goals is through the Great Expectations *for health* programs. These programs are designed to help you improve your overall health by providing you with written educational information and professional support from a team of health specialists. BlueChoice HealthPlan members may participate in these programs at no charge or for a small, one-time fee.

Great Expectations *for health* offers programs for:

- Asthma
- Children's Health
- Heart Disease
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Heart Failure
- Maternity
- Men's Health
- Migraine
- Quit Smoking
- Women's Health
- Weight Management.

For more information on these programs, please call the BlueChoice Health Management department at 800-327-3183, ext. 25541, or you may visit www.BlueChoiceSC.com.

The Free & Clear®†† Quit For Life™ Program

The research-based Quit For Life Program is available at no charge to BlueChoice HealthPlan subscribers and their dependents age 18 or older. On behalf of BlueChoice HealthPlan, Free & Clear administers a smoking cessation program. Free & Clear is an independent company that offers smoking cessation programs.

One of the most successful programs of its kind, the Quit For Life Program helps participants stop using cigarettes, cigars, pipes and smokeless tobacco. A professionally trained Quit Coach™ works with each participant to create a personalized quit plan. As part of the 12-month program, participants receive Quit Guides and five telephone calls from a Quit Coach. A participant may call Free & Clear's toll-free support line as often as he wishes. The program also provides free nicotine replacement products (patches, gum or lozenges), if appropriate. Your Quit Coach may also recommend your doctor prescribe a smoking cessation drug, such as bupropion or Chantix, which are available through your prescription drug coverage. The support line is available from 8 a.m. to midnight, seven days a week. If help is still needed after the 12-month program ends, you may re-enroll in the program.

To enroll in the Quit For Life Program, call 866-QUIT-4-LIFE (866-784-8454). After your eligibility is verified, you will be transferred to a Quit Coach for your first call.

Value-Added Services

There are many ways to stay healthy. That is why Value-Added Services are offered to BlueChoice HealthPlan members. These services and discounts are in addition to (but not a part of) the services and benefits covered under a BlueChoice HealthPlan policy.

Through the Natural Blue℠ program, you have access to special discounts on services from a network of acupuncturists, massage therapists, chiropractors, day spas and fitness centers in South Carolina and throughout the country.

Additional Value-Added Services include discounts for:

- LASIK services
- Alternative medicine

• Hearing tests and aids
• Weight loss programs and centers
• Magazine subscriptions
• Cosmetic surgery
• Cosmetic dentistry.

For more information or to find a provider, call Member Services at 800-868-2528 or go to www.BlueChoiceSC.com.

WEB SITE: WWW.BLUECHOICESC.COM

If you wish to download forms, learn specifics about your health plan, send BlueChoice HealthPlan an e-mail, review the Prescription Drug List or read about wellness programs, you can do all that and more by visiting www.BlueChoiceSC.com. This Web site is a protected, secure and convenient way for you to have access to timely information on your own schedule.

My Insurance Manager[sm†] enables you to:

- Review the status of your claims
- View and print a copy of your Explanation of Benefits
- See how much you have paid toward your deductible or out-of-pocket limit
- Ask a customer service question through secure e-mail
- Request a new ID card
- Access *My Pharmacy Manager.*

My Pharmacy Manager enables you to:

- View your prescription history
- Find information about medications you are taking or are considering taking
- Learn about potential therapeutic options to discuss with your physician
- Compare drug costs.

APPEALS

You have the right to appeal any decision by BlueChoice HealthPlan to deny an authorization for services you have requested or deny payment for services you have received.

To request an appeal, you (or your designated representative) may contact Member Services at 803-786-8476 (Columbia area) or 800-868-2528 (toll-free outside the Columbia area). If you prefer, you may send a written appeal request to:

? Do you need more information on appeals? If so, contact BlueChoice HealthPlan by phone, letter or e-mail.

BlueChoice HealthPlan
Member Services (AX-425)
P.O. Box 6170
Columbia, SC 29260-6170.

You may also e-mail your appeal request to BlueChoice HealthPlan through its Web site at www.BlueChoiceSC.com. Just sign on to *My Insurance Manager* and click on "Ask Customer Service."

You must file your appeal within six months of the date you were notified that the authorization or claim was denied. BlueChoice HealthPlan will reach a decision on your appeal and send you notification of that decision within 30 days of receipt of your appeal request.

If you are dissatisfied with the decision, you may ask for a review by sending a written request to the Employee Insurance Program (EIP) within 90 days of receiving notice of the decision on your appeal. If the EIP Appeals Committee upholds BlueChoice HealthPlan's decision, you will have 30 days to seek review in the S.C. Administrative Law Court pursuant to S.C. Code Ann. 1-23-380, as amended on July 1, 2006.

CIGNA HMO

CIGNA HMO, a traditional HMO plan administered by CIGNA HealthCare, is available in all counties in the state **except**: Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda.

Primary Care Physician

With CIGNA HMO, your primary care physician (PCP) is your first and primary source of medical care. The PCP you choose coordinates your medical care, including checkups, referrals to specialists, lab and X-ray services and hospital admissions.

When you enroll in CIGNA HMO, you and each covered member of your family chooses his or her own PCP. A woman may select an OB/GYN in addition to her PCP. A PCP can be a family/general practitioner, internist or pediatrician. PCPs are available to you 24 hours a day, seven days a week. If your personal doctor is not available, he will arrange for another doctor to take care of you.

NETWORK BENEFITS

With CIGNA HMO, you normally receive benefits for covered services **only** when you receive those services from participating physicians, hospitals and other healthcare providers. Network providers will:

- File claims for covered expenses for you
- Ask you to pay only the copayment and coinsurance amounts, if any, for covered expenses.

Copayments

Copayment amounts vary depending on the services you receive. The CIGNA HMO plan has no annual deductible. Copayments for doctor and hospital services under the plan are:

- $15 PCP office visit
- $15 OB/GYN visit
- $30 specialist office visit
- $30 chiropractic office visit
- $30 short-term rehabilitation visit
- $500 per inpatient hospital admission, then 20 percent
- $250 outpatient surgery and medical care per visit, then 20 percent
- $100 emergency care (waived if admitted)
- $500 per admission for inpatient mental health and substance abuse care
- $30 outpatient mental health and substance abuse office visit.

Coinsurance

You are responsible for 20 percent of the cost of hospital services received from network providers, in addition to the copayments. Emergency room services are covered at 100 percent after the copayments.

Coinsurance Maximum

Once you have spent either $2,000* (individual coverage) or $4,000* (family coverage) out of your pocket in a year for network services, the plan will pay 100 percent of your covered medical costs for the rest of the year.

Inpatient and outpatient hospital copayments and coinsurance count toward your out-of-pocket maximum. However, other copayments do not.

Prescription Drugs

The CIGNA plan provides prescription drug coverage. With CIGNA HMO, you **must** use a participating pharmacy (or mail service) when purchasing your medications. Benefits are not payable if you use a non-participating pharmacy. Copayments for up to a 30-day supply are:

- $ 7 for generics
- $25 for preferred brands
- $50 for nonpreferred brands.

CIGNA HMO offers an online prescription center (CIGNA TelDrug) that allows you to order prescriptions and refills for home delivery, review the list of covered drugs and check the status of a recent order 24 hours a day. The copayments for up to 90-day supply are:

- $14 for generics
- $50 for preferred brands
- $100 for nonpreferred brands.

OUT-OF-NETWORK BENEFITS

You may receive emergency services from out-of-network providers. If you have a life- or limb-threatening illness or injury, please go to the nearest hospital or treatment center, whether or not it is in the network. You or a family member should tell your primary care physician and CIGNA HMO about the emergency as soon as possible.

Members who are living in a state other than South Carolina are eligible for the Guest Privileges Program, a guest membership in an HMO in the community where they live, for up to two years.

If you or your dependent will leave your service area for more than 60 days, call 800-244-6224 to be set up with a provider network away from home. When you return, you can switch back to the South Carolina network.

EXCLUSIONS

These are examples of the exclusions in your plan. The complete list of exclusions is in your Certificate or Summary Plan Description. If there are differences, the terms of the Certificate or the Summary Plan Description control your benefits.

1. Any service or supply not described as covered in the Covered Expenses section of the plan
2. Any medical service or device that is not medically necessary
3. Treatment of an illness or injury that is due to war or care for military service disabilities treatable through governmental services
4. Any services and supplies for, or in connection with, experimental, investigational or unproven services
5. Dental treatment of the teeth, gums or structures directly supporting the teeth. However, charges for services or supplies provided for, or in connection with, an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of the accident
6. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, including clinically severe (morbid) obesity, including: medical surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity, and weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision
7. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations
8. Court-ordered treatment or hospitalizations

9. Infertility services, infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage
10. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction
11. Medical and hospital care and costs for the child of a Dependent, unless the infant child is otherwise eligible under the plan
12. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance
13. Consumable medical supplies other than ostomy supplies and urinary catheters
14. Private hospital rooms and/or private duty nursing except as provided under the Home Health Services provision
15. Artificial aids, including but not limited to, hearing aids, semi-implantable hearing devices, audiant bone conductors, bone-anchored hearing aids, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs
16. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery)
17. Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy
18. Non-prescription drugs and investigational and experimental drugs, except as provided in the plan
19. Routine foot care. However, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary
20. Genetic screening or pre-implantation genetic screening
21. Fees associated with the collection or donation of blood or blood products
22. Cost of the biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks
23. All nutritional supplements and formulae are excluded, except infant formula needed for the treatment of inborn errors of metabolism
24. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit
25. Expenses incurred for medical treatment by a person age 65 or older, who is covered under the plan as a retiree, or his dependent, when payment is denied by the Medicare plan because treatment was not received from a participating provider of the Medicare plan
26. Expenses incurred for medical treatment when payment is denied by the primary plan because treatment was not received from a participating provider of the primary plan
27. The following services are excluded from coverage regardless of clinical indications: massage therapy; cosmetic surgery and therapies; macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty/panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; transsexual surgery; non-medical counseling or ancillary services; assistance in the activities of daily living; cosmetics; personal or comfort items; dietary supplements; health and beauty aids; aids or devices that assist with non-verbal communications; treatment by acupuncture; dental implants for any condition; telephone consultations; e-mail and Internet consultations; telemedicine; health club membership fees; weight loss program fees; smoking cessation program fees; reversal of male and female voluntary sterilization procedures; and extracorporeal shock wave lithotripsy for musculoskeletal and orthopedic conditions.

SPECIAL FEATURES OF THE CIGNA PLAN

- **The CIGNA 24-Hour Health Information Line**[SM] gives members access to registered nurses who provide medical information and level-of-care counseling, an audio library of hundreds of health and wellness topics and guidance to network providers.

- **Healthy Rewards®** offers discounts on a variety of wellness programs including: Weight Watchers®, fitness club memberships, acupuncture, hearing aids and exams, chiropractic services and massage therapy.
- **Vision care.** Subscribers receive a $10 eye exam every two years. Not all providers participate, and you must use a participating provider.
- **Nationwide access** to specially trained experts and nationally recognized facilities through the CIGNA LIFESOURCE Organ Transplant Network.

LIFESTYLE MANAGEMENT PROGRAMS

CIGNA Quit Today℠ Tobacco Cessation Program helps you quit smoking or chewing tobacco. The yearlong program includes unlimited calls to your coach, an optional telephone relapse support group and over-the-counter nicotine gum or patches, if appropriate.

Strength & Resilience℠ Stress Management Program includes a stress risk assessment with your health coach, up to six coaching sessions during the first six months and unlimited calls to your coach for support.

Both programs are free. To enroll, call 866-417-7848 or go to www.myCIGNA.com.

CLAIMS

There is no paperwork for in-network care. Just show your CIGNA plan ID card and pay your copayment. Your provider will complete and submit the paperwork. If you visit an out-of-network provider, you or your provider must file a paper claim. You will receive an Explanation of Benefits identifying the costs covered by your plan and the charges you must pay. For more information on the claims process, please contact CIGNA HealthCare at 800-244-6224.

WEB SITE: WWW.MYCIGNA.COM

At CIGNA's secure, personalized Web site, www.myCIGNA.com, you can:

- Compare medical costs and providers
- Get prescription drug information and prices
- Keep track of your health information and take a health risk assessment
- Learn more about medical topics, health and wellness
- Order a new ID card, choose your doctor and learn more about your plan's benefits and features.

APPEALS

These steps must be followed if you have a concern or an appeal:

- Call or write CIGNA's Member Services Department, and a representative will work with you to resolve your concern.
- If it is not resolved to your satisfaction, you may appeal the decision to CIGNA's Appeal Committee. This is called a Level One Appeal. The Appeal Committee will notify you in writing of its decision within 30 calendar days.
- If you do not agree with the decision, you may appeal to CIGNA's Grievance Committee. This is a Level Two Appeal. The Grievance Committee will notify you in writing of its decision within 30 calendar days.

For more information on appeals, contact CIGNA Healthcare at 800-244-6224 or write CIGNA Healthcare at P.O. Box 5200, Scranton, PA 18505.

If you are still dissatisfied after CIGNA HealthCare has reviewed its decision, you may ask the Employee Insurance Program (EIP) to review the matter by making a written request to EIP within 90 days of notice of the denial. If the EIP Appeals Committee upholds the denial, you have 30 days to seek review in the S.C. Administrative Law Court pursuant to S.C. Code Ann. 1-23-380, as amended on July 1, 2006.

MUSC Options

MUSC Options is a self-insured, point of service plan. Health claims are processed by BlueChoice HealthPlan. Pharmacy claims are processed by Medco Health Solutions, Inc. (See page 86 for more information about pharmacy benefits.) Permanent, full-time eligible employees who live or work in Berkeley, Charleston, Colleton or Dorchester counties may enroll. The plan is also available to retirees (including those who are eligible for Medicare), survivors and COBRA subscribers who live in this area.

BENEFITS AT A GLANCE

To receive in-network benefits, all services must be provided by an MUSC Options participating provider. This applies to each individual service unless otherwise noted.

All non-emergency hospital admissions must be authorized by BlueChoice HealthPlan to be covered.

Benefits are subject to all (if any) limitations, deductibles, coinsurance and maximum payment amounts, exclusions, and limitations as specified in the Plan of Benefits.

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Deductible per Benefit Period		
(The benefit period is a calendar year.)		
Per member	$0	$ 500
Per family	$0	$1,500
Maximum Coinsurance per Benefit Period		
Per member	N/A	$3,000
Per family	N/A	$9,000
Lifetime Benefit Maximum - $1,000,000		
	Member pays	**Member pays**
Physician Services		
Primary Care		
Office visit	$25 copayment per visit	Deductible, then 40%
Hospital visit	$0	Deductible, then 40%
Screening mammogram	$0	100% (not covered)
Allergy injection and serum	$25 copayment per visit	Deductible, then 40%
Routine physical exam	$25 copayment per visit	100% (not covered)
Health assessment	$25 copayment per visit	100% (not covered)
Well baby and child care	$25 copayment per visit	100% (not covered)
Immunizations	$25 copayment per visit	100% (not covered)
Specialty Care		
(except mental health/substance abuse care)		
Office visit	$50 copayment per visit	Deductible, then 40%
Maternity care	$50 copayment for first visit	Deductible, then 40%
Hospital visit	$0	Deductible, then 40%
Surgery at hospital	$0	Deductible, then 40%
Emergency room care	$0	$0
Routine GYN exam	$25 copayment per visit	100% (not covered)
Non-routine GYN exam	$50 copayment per visit	Deductible, then 40%
Chiropractic care - spinal manipulation	$50 copayment per visit	100% (not covered)

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
	Member Pays	**Member Pays**
Facility Services (Except mental health/substance abuse care) (All services must be preauthorized except emergency care)		
Inpatient admission	$300 copayment per admission	Deductible, then 40%
Skilled nursing facility Lesser of $6,000 or 60 days per benefit period	$0	Deductible, then 40%
Outpatient services Lab and X-ray Surgical Diagnostic/therapeutic	$100 copayment per visit for first three visits per benefit period **(No copayment at MUSC facilities)**	Deductible, then 40%
Emergency room services	$150 copayment per visit (Waived if admitted)	$150 copayment per visit (Waived if admitted)
Urgent Care	$50 copayment per visit at a participating urgent care provider	Deductible, then 40%
Prescription Drugs **(**Administered by Medco Health: 800-711-3450)		**Covered only at a participating pharmacy**
Annual drug deductible for each covered person	$100	Member pays 100 percent.
Retail—Prescription Medication dispensed by a retail pharmacy is subject to one copayment for up to a 31-day supply.		
Tier 1 (Generic – lowest cost)	$10 copayment	
Tier 2 (Brand – higher cost)	$30 copayment	
Tier 3 (Brand – highest cost)	$50 copayment	
Specialty pharmaceuticals	$100 copayment per 31-day supply	
Mail Order—Prescription medication dispensed by a mail-order pharmacy is subject to one copayment for up to a 90-day supply.		
Tier 1 (Generic – lowest cost)	$25 copayment	
Tier 2 (Brand – higher cost)	$75 copayment	
Tier 3 (Brand – highest cost)	$125 copayment	
Specialty pharmaceuticals	$250 copayment per 90-day supply	
Mental Health/Substance Abuse Care In-network providers contract with Companion Benefit Alternatives (CBA) Members or participating providers must contact CBA at 800-868-1032 for authorization for in-network and out-of-network coverage.		
Inpatient	$300 copayment per admission	Deductible, then 40%
Outpatient	$50 copayment per visit	Deductible, then 40%

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
	Member Pays	Member Pays
Other Services		
Ambulance	$0	Deductible, then 40%
Home health Lesser of $5,000 or 100 visits per benefit period	$0	Deductible, then 40%
Hospice $6,000 lifetime maximum	$0	Deductible, then 40%
Medical supplies	$0	Deductible, then 40%
Surgical treatment of TMJ	$0	Deductible, then 40%
Original prosthetic appliances	$0	100% (not covered)
Outpatient mammograms	$0	100% (not covered)
Private duty nursing	$0	100% (not covered)
Rehabilitation services Physical, occupational and speech therapy are covered during the acute phase of treatment	$0	Deductible, then 40%
Dental services due to accidental injury within one year of accident	$0	100% (not covered)
Durable medical equipment (DME)	$0	100% (not covered)
Removal of bony, impacted wisdom teeth	$0	Deductible, then 40%
Infertility treatment Inpatient, outpatient and prescription medication limited to three cycles; $15,000 lifetime maximum	30%	100% (not covered)
Human Organ Transplants		
Inpatient		
Hospital care	$300 copayment per admission	Deductible, then 40%
Physician care	$0	Deductible, then 40%
Outpatient		
Office visit	$50 copayment per visit	N/A
Covered transplants **All non-experimental human organ transplants**		
Vision Care (any licensed vision care provider)		
Eye exam for eyeglasses or contact lenses once every benefit period	Balance over $75	Balance over $75
Eyewear covered once every other benefit period	Balance over $75	Balance over $75
Authorization not required		
Member pays for charges and submits claim for reimbursement		
Exams for the diagnosis or treatment of disease or injury to the eye (covered as a specialist visit)	$50 copayment per visit	100% (not covered)

YOUR PERSONAL PHYSICIAN

You are not required to select a personal physician. However, MUSC Options encourages you to coordinate your healthcare through one. By doing so, you may prevent unnecessary medical expenses, and you will ensure that your personal physician is up-to-date on the care you receive.

Finding a Network Provider

A complete list of providers is at www.BlueChoiceSC.com. If you would like a copy of the provider directory, you may request one by calling Member Services at 800-821-3023. You may also ask Member Services for more information about providers, including their qualifications and experience. Member Services can give you the most up-to-date information about changes in providers and about which ones are accepting new patients.

NETWORK BENEFITS

In the MUSC Options Network

You receive the highest level of benefits if you use the services of physicians and other providers that are part of the MUSC Options network.

You may go to a specialist in the MUSC Options network for office services without a referral from your personal physician.

Outside the MUSC Options Network

You may go to a licensed healthcare provider who is not in the MUSC Options network. However, you will be subject to coinsurance and a deductible, plus you may have to file your own claims.

Note: Not all services are covered outside the MUSC Options network. Please see the Covered Services section for more information.

Balance Billing

When you receive a covered service from a provider in the MUSC Options network, the provider is prohibited from billing you for more than any applicable copayments, coinsurance and deductibles. If you choose to receive a covered service outside the MUSC Options network, the non-network provider may charge you more than the plan's maximum allowable charge for the service. The difference between the plan's maximum allowable charge and the provider's higher charge is called the "balance bill." You will be responsible for paying the balance bill amount, along with any applicable copayments, coinsurance and deductibles. In addition, the balance bill will not apply to your out-of-pocket maximum.

COVERED SERVICES

Ambulance

Charges for emergency ambulance transportation provided by a licensed ambulance service to the nearest hospital where emergency covered services can be rendered are covered. Coverage includes transportation between acute care facilities when a medically indicated transfer is needed.

Behavioral Health Services

You are covered for treatment of mental health conditions and substance abuse. Companion Benefit Alternatives (CBA) coordinates benefits for these services. To receive services from a network or an out-of-network mental health or substance abuse professional, you or your physician may contact CBA at 800-868-1032 for authorization and/or more information.

Chiropractic Care

You are covered for office services from a chiropractor, including detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and the effects of such nerve interference, where such interference is the result of related distortion, misalignment or subluxation of, or in, the vertebral column. Diagnostic X-rays are covered if medically necessary. Other services that are within the scope of chiropractic care are also covered. *Chiropractic care is not covered out of network*.

Dental Services for Accidental Injuries

You are covered for dental services performed by a Doctor of Dental Surgery (DDS) or a Doctor of Medical Dentistry (DMD) to sound natural teeth when required because of accidental injury. For purposes of this benefit, an accidental injury is defined as an external traumatic force, such as a car accident or blow by a moving object. The first (emergency) visit to the dentist does not require authorization. However, the dentist must submit an outline of the plan for future treatment to BlueChoice HealthPlan for review and approval before continuing with follow-up care for that care to be covered. Follow-up care must be completed within 12 months of the accident.

Doctor Visits

Charges from your physician for office visits, including routine examinations, vision and hearing screenings, preventive care, injections, immunizations, well child care and health education, are covered. Charges from specialists for treatment or consultation are also covered. *Routine preventive care is not covered out of network.*

Durable Medical Equipment

Charges for medically necessary durable medical equipment, such as wheelchairs, braces, hospital beds, traction equipment, inhalation therapy equipment and suction machines, and other equipment as approved by BlueChoice HealthPlan for outpatient use, are covered. Equipment is covered only when ordered, delivered and used while you are enrolled in MUSC Options.

Repair, replacement or duplicates of durable medical equipment are not covered, except when medically necessary due to a change in your medical condition. Appliances that serve no medical purpose and are solely for your comfort, such as a whirlpool bath, air conditioner or dehumidifier, are also not covered. *Durable medical equipment is not covered out of network*.

Emergency Services and Urgent Care

Emergency Services

You are covered for treatment of a *true medical emergency* **anywhere** in the world. If practical, you should call your personal physician first and follow his or her directions. However, in the case of a serious medical emergency, go to the nearest hospital or treatment center for help or call 911. You should then have someone notify your doctor and BlueChoice HealthPlan.

For more information about the BlueCard program, see page 36.

MUSC Options will cover emergency room care only if you are seeking treatment for symptoms that are severe and need immediate medical attention, or if your doctor authorized the emergency room visit. Conditions that are considered a medical emergency include those so severe that if you do not get immediate medical attention, one of the following conditions could occur:

- Severe risk to your health, or with respect to pregnancy, the health of your unborn child
- Serious damage to body function
- Serious damage to any organ or body part.

Follow-up care for emergency services must be received from providers within the MUSC Options network or arranged by MUSC Options.

For more information on receiving emergency services outside the MUSC Options service area, review the section on the BlueCard program.

Urgent Care
Urgent care is a medical condition that is serious but not life- or limb-threatening. If you need urgent care, you should call your personal physician. If you have an illness or injury that requires urgent care and you cannot get to your doctor or wait until normal business hours, you should go to a participating urgent care center. Please refer to the MUSC Options Provider Directory for the list of participating urgent care centers.

Urgent care required within South Carolina is covered when provided by a participating urgent care provider. Urgent care required outside South Carolina is covered when coordinated through the BlueCard Program.

Out-of-network benefits are available for non-participating urgent care centers.

Hospice

You are covered for hospice care provided by a licensed hospice.

Human Organ Transplant Services

You are covered for certain human organ transplants. The organ must be provided from a human donor to you (the transplant recipient) and provided at a designated transplant facility. All solid organ (complete organ or segmental, cadaveric or living donor) procurement services, including donor organ harvesting, typing, storage and transportation are covered.

Please contact BlueChoice HealthPlan for more information regarding coverage for charges incurred by a living donor.

Transplants that are experimental, investigational or unproven are not covered. Transplants that are not determined by BlueChoice HealthPlan to be medically necessary are also not covered.

Infertility Services

You are covered for infertility services, including the following procedures and related services, supplies and prescription medications:

- Artificial insemination
- In vitro fertilization (IVF)
- Gamete or zygote intra-fallopian transfer (GIFT or ZIFT).

Coverage for infertility services is subject to the following terms and conditions:

- Benefits are provided as specified in the Schedule of Benefits.
- Benefits are limited to covered services provided to you or your enrolled spouse.
- Benefits for GIFT, ZIFT and IVF are limited to a maximum of three complete cycles with a $15,000 lifetime maximum.
- Coinsurance amounts are not included in the coinsurance maximum.
- Services for sperm banking/semen specimen storage are not covered.
- Services for any other assisted reproductive technology not specified herein are not covered.
- Fertility services are not covered out-of-network.

Inpatient Hospital Services

You are covered for inpatient hospital services at an acute care hospital, a skilled nursing facility or a long-term acute care hospital, including room and board, physician visits and consultations.

Maternity Care

You and your dependent spouse are covered for hospital care, birthing center care, and prenatal and postpartum care, including childbirth, miscarriage and complications related to pregnancy. Inpatient benefits are provided for the mother and newborn for 48 hours after normal delivery, not including the day of delivery, or 96 hours after Caesarean section, not including the day of surgery. Coverage for the newborn includes, but is not limited to, routine nursery care and/or routine well-baby care during this period of hospital confinement. Charges for home births are not covered. Pregnancy is not considered a pre-existing condition.

Medical Supplies

Charges are covered for medical supplies, including, but not limited to:

- Dressings requiring skilled application, for conditions such as cancer or burns
- Catheters
- Colostomy bags and related supplies
- Medically necessary supplies for renal dialysis equipment or machines
- Surgical trays
- Splints or such supplies as needed for orthopedic conditions
- Syringes, test tapes, and other related diabetic supplies not covered under other provisions of the plan.

Outpatient Hospital Services

Charges for outpatient laboratory, X-ray, surgery and diagnostic tests are covered. Physical therapy, occupational therapy, and speech therapy are also covered subject to the limits listed in the Schedule of Benefits.

Outpatient Private Duty Nursing Care and Home Health Services

You are covered for special or private duty nursing care provided by a registered nurse or a licensed practical nurse on an outpatient basis. Services must be provided in lieu of inpatient care.

You are covered for home health services provided by a licensed home health agency. Services must be provided in lieu of inpatient care.

Prosthetics

You are covered for a prosthetic device, other than a dental or cranial prosthetic, that is a replacement for a body part and meets minimum specifications. Only the initial prosthesis is covered. *Prosthetics are not covered out of network.*

Reconstructive Surgery after a Mastectomy

If you are receiving benefits in connection with a mastectomy and/or elective breast reconstruction in connection with the mastectomy, you are covered for mastectomy-related services including:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications during all stages of mastectomy, including lymphedemas.

This coverage is in compliance with the Women's Health and Cancer Rights Act of 1998.

Rehabilitation Services

You are covered for short-term (acute phase of treatment) rehabilitation services that are expected to significantly improve your condition. Rehabilitation services are limited to physical therapy, occupational therapy, speech therapy and cardiac therapy. Speech therapy is covered only when used to restore speech abilities that have been lost due to injury or illness. Cardiac therapy is covered only after a major cardiac event.

Therapeutic Services

Charges for radiation therapy, cancer chemotherapy and respiratory therapy are covered.

Vision Services

You are covered for vision services from any licensed vision care provider without authorization. Your plan will pay up to $75. However, you are required to pay the provider's total charge and submit a claim to BlueChoice HealthPlan for reimbursement. See your Schedule of Benefits for more information on covered vision services.

PRESCRIPTION DRUG PROGRAM

MUSC Options participates in Rx Selections®, Medco Health Solutions, Inc.'s pharmacy network. For a list of participating providers, go to www.eip.sc.gov. **Remember, benefits are only payable if you use a participating pharmacy or mail-order pharmacy.** You **must** show your ID card when purchasing medications.

Prescription Drug Deductible and Copayments

MUSC Options has a $100 prescription drug deductible. This means that each person covered under the plan, including dependents, must pay $100 in allowable charges for covered prescription drugs before he can purchase covered prescription drugs for the copayment.

After you reach your $100 deductible, you pay these copayments for up to a 31-day supply:

$10 tier 1 (generic – lowest cost)
$30 tier 2 (brand – higher cost)
$50 tier 3 (brand – highest cost)
$100 for specialty pharmaceuticals.

After you reach your $100 deductible, you pay these copayments for a 90-day supply of a prescription ordered from Medco's mail-order pharmacy:

$25 tier 1 (generic – lowest cost)
$75 tier 2 (brand – higher cost)
$125 tier 3 (brand – highest cost)
$250 for specialty pharmaceuticals.

Pay the Difference

If a generic drug is available and you purchase the brand-name version instead, the benefit will be limited to the cost of the generic drug, even if your doctor instructs the pharmacist to "dispense as written." You will be responsible for paying the difference between the cost of the generic drug and the cost of the brand-name drug.

COORDINATION OF BENEFITS (COB)

MUSC Options coordinates prescription drug benefits and medical benefits. When you are covered by more than one insurance plan, COB makes sure you are not reimbursed more than once for the same expense and that each plan pays its fair share of the cost of your care.

When you are covered by more than one plan, the plan that pays first is the *primary* plan. The *secondary* plan pays after the primary plan. MUSC Options determines which plan is primary. Here are some examples of how that works:

The plan that covers a person as an employee is primary to the plan that covers the person as a dependent. When both parents cover a dependent child, the plan of the parent whose birthday comes earlier in the year is considered primary.

Prescription Drugs

When filling a prescription at a participating pharmacy, you may notice a difference in the amount MUSC Options pays.

If MUSC Options is primary
When you purchase a prescription drug, present your MUSC Options insurance card first. Your claim will be processed under the plan as if you had no other coverage. Then present the card for your secondary insurance coverage. If the pharmacy can pay secondary insurance claims electronically, benefits under that plan will be paid.

If MUSC Options is secondary
Present the card for your primary coverage first. If you present your MUSC Options card first, the claim will be denied because the MUSC Options is secondary. After the pharmacy processes the claim through your primary coverage, present your MUSC Options card, and your claim will be processed through MUSC Options.

If the pharmacy cannot process secondary insurance claims electronically, the claim may be rejected. If this happens, you will need to file a paper claim to Medco for any MUSC Options benefits. Prescription drug claim forms are available through the EIP Web site at www.eip.sc.gov. Choose your category ("Active Subscriber," for example) and then select "Forms." You will see both the retail and mail-order pharmacy forms listed. Forms also are available from your benefits administrator.

Please remember: MUSC Options is not responsible for filing or processing your claims through another health insurance plan. That is your responsibility.

EXCLUSIONS AND LIMITATIONS

Although this plan covers a broad range of services, there are some exclusions and limitations. The following is a list of some of them. For a complete list of all exclusions and limitations, consult the Plan of Benefits.

1. Any services or supplies that are not medically necessary
2. Any services or supplies for which you are not legally obligated to pay
3. Any services or supplies for treatment of military service-related disabilities when you are legally entitled to other coverage and for which facilities are reasonably available to you
4. Any services or supplies for which benefits are paid by Workers' Compensation, occupational disease law or similar legislation
5. Treatment of an illness contracted or injury sustained while engaged in the commission or an attempt to commit an assault or a felony; treatment of an injury or illness incurred while engaged in an illegal act or occupation (job); or treatment of an injury or illness due to voluntary participation in a riot or civil disorder

6. Any charges for services provided before your effective date or after the end of coverage
7. Admissions or portions thereof for sanitarium care, rest cures or custodial care
8. Any services or procedures for transsexual surgery or related services provided as a result of complications of such transsexual surgery
9. All services and supplies related to pregnancy of a dependent child (Complication of pregnancy is covered. However, abortion is not considered a complication of pregnancy)
10. Pre-conception testing, pre-conception counseling or pre-conception genetic testing
11. Any drugs, services, treatment or supplies determined by the medical staff of BlueChoice HealthPlan, with appropriate consultation, to be experimental, investigational or unproven
12. Drugs for which there is an over-the-counter equivalent; all vitamins, except prenatal vitamins; drugs not approved by the Food and Drug Administration; drugs for non-covered services, therapies or conditions; and drugs prescribed for obesity or weight control, cosmetic purposes, hair growth, sexual dysfunction or smoking cessation, except in conjunction with the Free and Clear® Quit for Life™ Program
13. Plastic or cosmetic surgical procedures or services performed to improve appearance or to correct a deformity without restoring a bodily function, unless such services are medically necessary and due to physical trauma, surgery, or congenital anomaly (birth defect)
14. Therapy or services for learning disabilities, speech delay, stuttering, perceptual disorders, mental retardation, behavioral disorders, vocational rehabilitation and marriage counseling
15. Any service or supply rendered to a person for the diagnosis or treatment of sexual dysfunction including, but not limited to, surgery, drugs, laboratory and X-ray tests, counseling, or penile implant necessary due to any medical condition or organic disease
16. Hospital and physician services for dental procedures involving tooth structure, extractions, gingival tissue, alveolar process, dental X-rays or other procedures of dental origin that are principally for the preserving of teeth or the preparation of the mouth for dentures, even when due to accidental injury of natural teeth except for the following:
    a. Treatment of an injury to sound natural teeth due to an accident if the treatment is provided and completed within 12 months after the accident
    b. Removal of a malignant tumor or cyst
    c. Removal of bony, impacted wisdom teeth.

    This exclusion does not apply to facility and anesthesia services that are medically necessary because of a specific organic medical condition, such as a congestive heart failure or chronic obstructive pulmonary disease, that requires hospital-level monitoring.
17. Hearing aids
18. Charges incurred as the result of a missed scheduled appointment and charges for the preparation, reproduction or completion of medical records, itemized bills or claims forms
19. Services or supplies not specifically listed in the Schedule of Benefits or the Covered Services section
20. Transplant services other than as specified in the Schedule of Benefits or the Covered Services section
21. Complications arising during, from or related to non-covered services. "Complications," as used in this exclusion, includes any medically necessary services or supplies which, in BlueChoice HealthPlan's judgment, would not have been required by you had you not received non-covered services
22. The purchase or rental of air conditioners, air purifiers, motorized transportation equipment, escalators or elevators, swimming pools, water beds, exercise equipment or other similar items or equipment
23. Any service or supply provided by a member of your family or by yourself, including the dispensing of drugs. "A member of your family" means your spouse, parent, grandparent, brother, sister, child or your spouse's parent
24. Charges for acupuncture, hypnotism, biofeedback and TENS unit. Services for chronic pain management programs or any program developed by centers with multidisciplinary staffs intended to provide the interventions necessary to allow you to develop pain coping skills and freedom from dependence on analgesic medications

25. Orthomolecular therapy, including nutrients, vitamins and food supplements, that is aimed at or related to restoring the optimal concentrations and molecular level functions of substances, such as non-traditional vitamins and base elements in the body through the use of macrobiotics
26. Radial keratotomy, myopic keratomileusis, LASIK surgery and any surgery that involves corneal tissue for the purpose of altering, modifying or correcting vision problems such as myopia, hyperopia or stigmatic error
27. Treatment of weak, strained or flat feet, including orthopedic shoes or other supportive devices, for services and supplies for non-surgical treatment of the feet, or for cutting, removal or treatment of corns, calluses or nails. This exclusion does not include corrective surgery, or treatment for metabolic or peripheral vascular disease
28. Infant formula, nutrition counseling, lifestyle improvements or physical fitness programs
29. Communications, travel time, transportation, except for use of professional ambulance services
30. Cranial orthotics used on infants with misshapen heads to progressively mold the skull to a normal shape
31. Sclerotherapy for cosmetic purposes, such as removal of spider veins
32. Growth hormone therapy for patients over 18 years of age (Growth hormone therapy for patients age 18 and younger with documented growth hormone deficiency is covered)
33. Pulmonary rehabilitation, except in conjunction with a covered lung transplant
34. Charges for services or supplies from an independent healthcare professional whose services are normally included in facility charges
35. Surgery for treatment of obesity, including, but not limited to, gastric bypass or stapling, intestinal bypass and any related procedures. Benefits for the surgical revision, reversal or the treatment for the consequences of bariatric surgery, such a abdominoplasty, are limited to procedures which are medically necessary to treat intractable functional problems that are refractory to medical or non-surgical treatment
36. Treatment for weight reduction, weight control, or nutritional counseling, except for the MUSC Weight Management Program
37. Any procedure, drug, treatment or service for or related to an elective abortion
38. Services or supplies related to dysfunctional conditions of the muscles of mastication, malpositions or deformities of the jaw bone(s), orthognathic deformities or temporomandibular joint (TMJ) disorders except for surgical treatment of TMJ
39. Voluntary sterilization within one year of enrollment in any of the medical plans sponsored by the Employee Insurance Program (EIP).

OTHER PLAN FEATURES

Away From Home Care

Any time you or one of your family members will be out of South Carolina for more than 90 days, you can become a guest member of an affiliated Blue Cross Blue Shield health plan near your destination. Just call BlueChoice HealthPlan and explain your situation. Students and long-term travelers are two groups that can benefit from Away From Home Care. If you need to use the Away From Home Care program, call Member Services at 803-382-5026 (Columbia area) or 800-821-3023 (toll-free outside the Columbia area) and ask to speak to the Away From Home Care program coordinator, or visit www.BlueChoiceSC.com for more information.

Great Expectations®† *for health*

Great Expectations *for health* programs are designed to help you improve your health by providing you with educational information and professional support from health specialists. MUSC Options members may participate in these programs at no charge or for a small, one-time fee.

Great Expectations *for health* offers programs for:

- Asthma
- Children's Health
- Heart Disease
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Heart Failure
- Maternity
- Men's Health
- Migraine
- Quit Smoking
- Women's Health
- Weight Management.

For more information on these programs, call the Health Management department at 800-327-3183, ext. 25541, or you may visit www.BlueChoiceSC.com.

The Free & Clear® Quit For Life™ Program

The research-based Quit For Life Program is available at no charge to MUSC Options subscribers and their covered dependents age 18 and older.

One of the most successful programs of its kind, the Quit For Life Program helps participants stop using cigarettes, cigars, pipes and smokeless tobacco. A professionally trained Quit Coach™ works with each participant to create a personalized quit plan. As part of the 12-month program, participants receive Quit Guides and five telephone calls from a Quit Coach. A participant may call Free & Clear's toll-free support line as often as he wishes. The program also provides free nicotine replacement products (patches, gum or lozenges) if appropriate. Your Quit Coach may also recommend your doctor prescribe a smoking cessation drug, such as bupropion or Chantix, which are available through your prescription drug coverage. The support line is available from 8 a.m. to midnight, seven days a week. If the participant still needs help after the 12-month program ends, he may re-enroll in the program.

To enroll in the Quit For Life Program, call 866-QUIT-4-LIFE (866-784-8454). After your eligibility is verified, you will be transferred to a Quit Coach for your first call.

Value-Added Services

There are many ways to stay healthy. Value-Added Services are offered in addition to, but not a part of, the services and benefits covered under the MUSC Options plan. Through the Natural Blue program, you have access to special discounts on services from a network of acupuncturists, massage therapists, chiropractors, day spas and fitness centers in South Carolina and throughout the country.

Additional Value-Added Services include:

- LASIK services
- Alternative medicine
- Hearing tests and aids
- Weight loss programs and centers
- Magazine subscriptions
- Cosmetic surgery discounts
- Cosmetic dentistry discounts.

For more information or to find a provider, please call Member Services at 800-821-3023 or visit www.BlueChoiceSC.com.

MEDICAL WEB SITE: WWW.BLUECHOICESC.COM

If you wish to download forms, learn specifics about your health plan, send BlueChoice HealthPlan an e-mail or read about wellness programs, you can do all that and more at www.BlueChoiceSC.com. This Web site is a protected, secure and convenient way for you to read timely information on your own schedule.

My Insurance Manager enables you to:

- Review the status of your claims
- View and print a copy of your Explanation of Benefits
- See how much you have paid toward your deductible or out-of-pocket limit
- Ask a customer service question through secure e-mail
- Request a new ID card.

PRESCRIPTION DRUG WEB SITE: WWW.MEDCO.COM

Prescription drugs are a major benefit offered through your HMO and a major cost of our self-insured health plans. Learning more about them will help you stay healthier and save money. For more information about your drug plan, visit www.medco.com.

Medco's Web site enables you to:

- Order prescriptions by mail
- Learn about savings opportunities
- Price drugs
- Print forms
- Find a network pharmacy
- Review up to 18 months of your prescription drug history
- Get up-to-date information about your drug benefits.

APPEALS

You have the right to appeal any decision by BlueChoice HealthPlan to deny an authorization for services you have requested or deny payment for services you have received.

To request an appeal, you (or your designated representative) may contact Member Services at 803-382-5026 (Columbia area) or 800-821-3023 (toll-free outside the Columbia area). If you prefer, you may send a written appeal request to:

BlueChoice HealthPlan
Member Services (AX-425)
P.O. Box 6170
Columbia, SC 29260-6170.

You may also e-mail your appeal request to BlueChoice HealthPlan through www.BlueChoiceSC.com. Just sign on to *My Insurance Manager* and click on *Ask Customer Service*.

You must file your appeal within six months of the date you were notified that the authorization or claim was denied. BlueChoice HealthPlan will reach a decision on your appeal, and send you notification of that decision, within 30 days of receipt of your appeal request.

If you are dissatisfied with the decision, you may ask the Employee Insurance Program (EIP) for a review by sending a written request to EIP within 90 days of receiving notice of the decision on your appeal. If the EIP Appeals Committee upholds BlueChoice HealthPlan's decision, you will have 30 days to seek review in the S.C. Administrative Law Court pursuant to S.C. Code Ann. 1-23-380, as amended on July 1, 2006.

If you need more information about the appeal process, contact Member Services by phone, letter or e-mail as indicated above.

For information about appealing decisions of Medco Health Solutions, your prescription drug benefits manager, see page 61.